Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1- State Registrar amend item 11 per fh g882 8-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 GATES Day 07 Month August **Physician** D:00 4M EWIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ∏ M 2 □ F **Funeral** Days 64 219-40-3931 4-18-1944 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No X X Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2536 Robb Street 21218 IJ S A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Š **3€Wido**wed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 2 should be filed with and Mental Hygiene. 12th grade Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ Pages 1 and 2 should be Lewis Gates Evelyn Hawks 0 19a. Informant's Name/Relationship (Type. Print)
Florence
Frances Gates-Wif 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rances Gates-Wife 2536 Robb Street Baltimore, MD 21218 Health 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If It any Injury or o Cemetery 8-15-08 Balto, MD Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la Warne 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due of (or as of convequence of): MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 Inknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death, Funeral Director: After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Physician: 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA ပ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 053368 10,2008 30. Name angladdress of person who completed cause of death (Item 23a) (Type, Print) MD eter 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year)
AUG 1 3 2008 32. Registrar's Signature State 3 AUG Registrar

DHMH 17 Rev 1/2001

Rudy Riexander Maldanado Guzman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 26002

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		4a. Facility Name (if not institution Johns Hopkins Hospital))	14	b. City, To Baltimo		ocation of De	ath	40	N/A	tn	
Europoli		Social Security Number		e (In yrs. Ia	ast birthday)	If Under		If Under 24	Hrs. 8. Date of	Birth(MM/	/DD/YYYY) 9. B	irthplace (State or	
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5-0036 fled within 7. Hygiene I other than	mo	1 0 17. Father's Name (First, Middl	e Last)		CO	UK	1	RESTAURANT 8. Mother's Name (First, Middle, Maiden Surname)					
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imore, MD 21215-0036 Pages I and 2 should be filted within 72 hours after death with the Maryland ment of Health and Mental Hygiene with a firm 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		JAIMEN LEIV	A/ BROTHER	Look	2142 Place of Dispos				UE, BAL		ORE, MD.	21206 or Town, State	
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1 of Vital Records, Jing Physician: The law requit After this certificate has been s funeral director, page 2 should	⊢	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir	njury	28b. Time of		28c. Injur	ry at Work?			injury occurred		
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the											and manner as : place, and due t	stated. o the cause(s)	
To the within 2 To the complet	Med	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number											
	-	1 1K.		O.C.M.E.					29d. Date signed (Month, Day, Year) August 8, 2008				
3		30. Name and do ess of pers	con who completed cause of	of death (Ite	em 23a)								
Ş		Pamela E. Southall	, MD Assistant Me	edical Ex	aminer 1	11 Penr	Stree	t, Baltimo	re, MD 2120	1			
Regis	State	16 1 16 1 1 1 1	2008 Regis	trar's Sign	ture Coas	L'							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 7, 2008 Year **Physician** Mahatun Mallawaarachchi Gamage 8:18 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 € M 2 □ F 80 213-61-3183 Yrs. June 23, 1928 Sri Lanka Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 Travis View Court 20879 Sri Lanka Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Sinhalese Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Journalist Newspaper 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sumanahami Benthara Vithana

Podiappu Mallawaarachchi Gamage 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 Travis View Court, Gaithersburg, Maryland 20879

Santhi Hewagama/ Daughter 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc.

Date

20c. Location - City or Town, State Bethesda, Maryland

21. Signature of Funeral Service Licensee

4 ☐ Donation 5 ☐ Other (Specify)

22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Bethesda, Maryland 20814. Pumphrey Funeral Home/ 7557 Wisconsin Avenue M01498

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minale

3 Ectopic pregnancy

23d. Date of delivery Month Day

IF FEMALE: 23b. Was decedent pregnant

Physician/Medical Examiner

Completed by

Certification: To Be

in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9☐Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy
performed?
1 Vac 2 TLK

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Dinpatient 5 ☐ Pending investigation

2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 🗌 Yes 2 No

28d. Describe how injury occurred

29a. Certifier

27. Manner of Beath

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tipe of certifier

600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

53601

ARK

29c. License number

29d. Date signed (Month, Day, Year) 08

Location (Street and Number or Rural Route Number, City or Town, State)

State

Registrar

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

use as the burial-transi

attending physician for use as the hurial

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this certificate has been

within 24 hours after death, To the Funeral Director: Af completely filled in by the fu

funeral director,

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day,

6 ☐ Could not be

determined

AKOMA Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death ugusi **Physician** Vivian Hamilton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Hospital PG anham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours Months 578-56-5124 6 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show items 23a or 28a-f showing the result of the state of the 1 Yes 2 No Funeral Director MD apital 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5801 Junipertree 2074 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Peges 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examinany injury or other traumatic event, the Medical Examinants. Hamilfon, VIVan altimore, Maryland 21215-0036 1 Tyes 2 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ter Operators Federal Cont Superison 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan: 1 Calhon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other J. Hamilton Ft Wash MD 20744 20b. Place of Disposition (Name of Cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-14-2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility elta a. 8144pshur St XIW Mush TRT-State Hackin F/S 23ar art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Endometrial Canan Unknow /Medical Due to (or as a consequence of) Examiner Unknow. Colon Caren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed 1 ☐ Yes 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8.9.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave Suit 3-325. /ver ROINTAN FARAHIFAR Begistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 1

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year Physician 5:50 ам August 4, Phyllis Rose Ho1tman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Caton Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 6) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) ^{Ye}1'925 **Funeral** Months Days Hours Min. Mary land 1 □ M 2 🗗 F 82 217-20-0392 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, It is Moviced Examinating must be recified at 1 Yes 2 No Directo **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 3235 Kingsley Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: White 3 Widowed 41 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Weinberg Center 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corneila Hoffman Diehlmann Daniel ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3235 Kingsley St., Baltimore, MD 21229 19a. Informant's Name/Relationship (Type. Print) Kathy Holtman (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/7/08 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 2 Days 23a. Part + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner 6 Months Carcinoma Breast Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): ng physician as the burial P.O. Box 68760 Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? P Month Year 5 Other (specify) been signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 XNatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Medical f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O8 **Physician** OS 2008 2100 M Hyman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TMORE 000 Damar If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day Social Security Number 6. Sex (In yrs. last birthday) If Unde /ear 9. Birthpiace Country) (State or Foreign **Funeral** Days Months 1 □ M 2 ▼ F 062-48-8228 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director Timor 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 10 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Mamed 2 X No 1 ☐ Yes 2 ☐ Xo Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RN MEDICA L 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be itnix 2501 1040 ၉ man Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) rkville No · Davahla OWHAREA 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ exemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -13-08 MARU letro Signature of Funeral Service Licenses 22. Name and Address of Faility Ua 4600 BRRTY modia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Cardiac arrhymnia **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 \(\subseteq No certificate 1X Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 [Inpatient this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident **Director:** filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Johns

3. Registrar's Signature

The

21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 26007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician P M Edward Jasper Harris 11:07 03 /Medical August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Harborside Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 212-42-3204 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2 ☐ F 63 Director Dec. 23. DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** MD YYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 3847 Lyndale Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora Knight James E. Harris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3847 Lyndale Avenue; Baltimore, Maryland 21213 19a. Informant's Name/Relationship (Type. Print) Barbara Joyner / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Surial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/09/2008 Baltimore, Maryland Mount Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any the input of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed the burial-transit Due to (or as a consequence of) physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.0. been signed by the sahould be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Vital Records, 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 🗹 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ro the Hospital or within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Worldham Woods Road · Saik John 121234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 1813

32. Registrar's Signature

(Month, Day, Year) UG 1 3 2008

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

HODKINS

10M 20 F

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical

10b County

Jeorge

5. Social Security Number

10a. State

217 38 0156

Usual Residence of Decedent

show other traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Anne Arundel Glen Burnie Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Funeral [211 Somerset Drive Apt. 102 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1958 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1962 1 ☐ Yes 2 X No Specify: þ Specify: 3 □ Widowed 4 □ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Colonial Dental Lab. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hopkins Helen Gorecki ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If Item 27 Is I Donna Niesz 211 Somerset Bay Dr. Apt. 102 Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If It any Injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem. 08/12/2008 Crownsville, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a-diavascular Collaise /Medical Due to (or as a consequence of): Examiner Multi-Organ Failur Dus to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Sensis Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) 9 H Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 **☑** No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5, homas gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 13 2008 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Contes

7. Age (In yrs. last birthday)

10c City Town or Location

Certificate of Death

Months

4b. City. Town, or Location of Death

Bultimore
If Under 1 Year | If Under 24 Hrs.

Hours

Days

Reg. No. 2008

Year

2008

4c. County of Death

3. Time of Death

33

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

2. Date of Death

8. Date of Birth (Month, Day, Year) 12/25/1940

August

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05970 State of Maryland / Department of Health and Mental Hygiene 2008 26009 Charles E. Hughes, III Certificate of Death Reg. No. 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 4, 2008 1120 hrs Charles E. Hughes III Examiner Mer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or DC If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Washington **Funeral** Days Hours Months 212-04-0188 12/10/1977 XM 30 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ű 1 X Yes 2 No Upper Marlboro 123a or 28a-f show notified at once, MD Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 8833 Heather Moore Blvd #I2 20772 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married Never Married 2X No Yes Black 1 Yes 2 X No specify: Specify: If Yes, Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) P. G. County Police Officer BS Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Washington Charles Edward Hughes, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8833 Heather Moore Blvd #I2; Upper Marlboro, MD 20772 LaKrisha A. Hughes - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) XBurial 2 Cremation 3 Removal from State 08/12/2008 Suitland, Maryland Lincoln Memorial Cemetery permit. Page Department o Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services Signature of Fun, ral Servine Licenses 4594 Beech Road; Temple Hills, Marylnd 20748 art I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and vysician filure. List only one cause on each line. Death a Acute Coronary Artery Thrombosis dical Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. sician/Medical AMENDED UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE FEMALE: Year Day 3 Ectopic pregnancy Month Fetal death 23b. Was decedent pregnant in the Live birth use as 1 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions o Yes 2 ✔ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, s been s prior to completion of cause of autopsy performed? death? has 1 🗸 Yes No ✓ Yes 2 certificate 26.Place of Death (Check only one) 25 Was case referred to medical Other₄ Be Residence 6 Other Hospital: Nursina Home 5 DOA 2 CER/Outpatient 3 Inpatient this 1 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: Yes 2 1 V Natural Pending Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 5, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Remetrar's Signature 31. Date filed (Month, Day, Year, State 200 Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 3:35 A M August Bruce Gregory Hardzog /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F February 9, 1955 Kansas Director 508-70-1792 53 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Modical Evandra, it will be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 121 Crofton Hill Lane 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marketing Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Croom Walter A. Hardzog, Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 121 Crofton Hill Lane, Rockville, Maryland 20850 Lisa A. Hardzog /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State Date 20a. Method of Disposition August 9 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue
M01360 Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 Hours Intra-Cerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Myocardial Infarction Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number ၉ Whow Zewdie, MD D0067593 Name and address of person who completed cause of death (Item 23a) (Type, Print) 990/Hedied Center Drive Rockwille Lowdie MD 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Vear **Physician** 12:25P M Nannie Bell Jones 8 8 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1710 E. 29th Street Balto N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 231-46-0580 Director VA 3-25-1936 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show d other than "natural", or Items 23a or 28a-f show event, its Medical Examples inside conflict at 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with 29th Street 1710 E. USA Funeral 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXIVo Specify Specify: ¥ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Medical Unit Clerk 13th grade 2 years th and Mental Hygie 7 is marked other tl Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any linjury or other traumatic event othe. Be John Henry Puryear Abbie Lou Speaks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 E. 29th Street Balto, MD 21218 Cynthia Jones-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 8-14-2008 Randallstown, MD King Memoiral Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): carre /Medical Examiner Due to (or as a consequence of): Luces Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Box 68760,44 and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a I ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 □Yes 2 □No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, prompletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 Residence 6 □ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Dath 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation MA 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nuran varqueute 00008093 Wh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mg. 212 18 33 M Delomine 200 EAST 31. Date filed (Month, Day, Year)
ALIG 13 2008 32. Registrar's Signature State AUG 1 Registrar

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 amend #10e&17 Per INF G882 8/28/108te of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Tyling Year **Physician** 40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OWSIS >1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year, 1 □ M 2 € Months Hours Days 86 5323 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, I've Medical Examinar must be notified at 1 Xes 2 No Director 2709 21225 10g. Citizen of What Country? Spellman Road 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Funera Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during n life, DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other transmatic. Elementary/Secondary (0-12) College (1-4or 5+) 17, Father's Name (First, Middle, Last) Joseph **Townes** 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Girect and Number or Rural Route Number, City or Town, State, Zip Code) Mothe 3170 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 Burial 2 □ Cremation 3 □ F 3 ☐ Removal from State Mu 21. Signature of Funeral Service Licenses 22. Name and Address of Facility the 2120 4600 UBER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** whosis disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown The law requires that Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown been Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy To the Hospital or Attending PhysIcian: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) No pice ŽV No Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natura. 2 □ Accident 5 ☐ Pending investigation 1 □Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

AUG

3

w 32 Registrar's Signature

NUES

ORIGINAL

		4	For State	State of	Marylan		rtment of h			-				
			Registrar 1. Decedent's Name (First, Middle,	(ant)		Cei	tificate of	Deatr	7	2. Date of De	Reg. No. 2	108	26	0 .
Phys				,	Loweth					Month	Day	Year	1 • 2	O A ^M
/Me	dica		4a. Facility Name (If not institution,				4b. City, Town, o	r Location	n of Death	Augus	4c. County	2008_ y of Death		<i>J</i> A
LAGI			Southern Mary	land Hosp	ital		(Clint	on		Pri	ince	George	's
Funer	al		,	5. Sex 7 1 □ M 2 □ F	Age (In yrs.		If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da	th 4, Year) 4, 1937	9. Birth	place (State of Intry)	or Foreign
Direct	or	-	214-34-7095 Usual Residence of Decedent	XWIZET	70	Yrs.				Nov. I	4, 1937	Was	ningto	n DC
/land	e l	-	10a. State 10b. County		10c. Cit	ty, Town or Lo		-					10d. Inside C	ity Limits
a-fsh		cto	NC Hende	rson			Hende	erson	ville	3			1 Yes	2 🗆 No
ith the		Director	10e. Street and Number				10f. Zip Code				10g. Citizen of		-	
s 23a		<u>a</u>	540 Blythe S			2 42 1		28739		76 N N	Unite			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Macal Experiment any Injury or other traumatic event, Ite Macal Experiment, and be notified at	L	by Funeral	11. Marital Status 1 □ Never Married 2 【X Marrie	If Yes, Give	ces? 2 □ No e		Vas Decedent of H fYes, specify Cub I∐Yes 2 XNo			ecity Yes or No Rican, etc.)	14. Ha Bla Specii	ıck, White,	ican Indian, , etc. Thite	
hours tural'	N. H. V.		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Da	tes:	16a Decer	dent's Usual Occui	nation			16b. Kind of B	lusiness/l	ndustry	
in "na In "na	1	Completed	(Specify only highest Elementary/Secondary (0-12)		for 5 i	(Give	kind of work done DO NOT use retire	during mo d)	ost of worki	ing		don room	nddoll y	
d with giene ger than		<u>ج</u>	12	College (1-	+01 3+)	A:	ircraft l	Mecha	nic		Aero	ospac	:e	
be file tral Hy d oth		å R	17. Father's Name (First, Middle, Li		_	. 1		18. Mot			, Maiden Surnai 1		1	
y out		<u> </u>	Donald	Charles	Lowe	1		L	Deave		lenor		acken	
d2st d2st lth an 17 is r traur			19a. Informant's Name/Relationshi Vanessa Loweth				ig Address <i>(Street</i> Blythe St				-	1, State, 2. 3873		
s t an if Hea if tem 2		1	20a. Method of Disposition		20b. F		sition (Name of natory or other pla			Date	20c. Location	- City or T	own, State	
Page nent o			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from Secify)	tate i	ience		<i>ce)</i>	8/13	3/08	Phoe	nix,	AZ	
partit. Departin	ouce.		21. Signature of Funeral Service Li		10038	2 22	Name and Address Rapp Fund 933 Gist	eral	& Cre	emation	Service	es		
			23a. Part 1. Enter the disease, or c	omplications that ca	used the deat		-100		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TO DO		D 2	Approximat	ie
Physicia	n		shock, or heart failure. List o			0	, <u>T</u>						Interval Bet Onset and	ween Death
/Medic	al		disease or condition resulting in death)		r as a conseq	uence of):	ial Tu	<u>م</u> دا.	_					
Examine	•		Sequentially list conditions	b (Z	encl	Call	car	cin	om c	`				
ed sit			Sequentially list conditions, the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	ras a conseq	tience of):								
sxecul and al-tran		Examiner	that initiated events resulting in death) Last	c Due to (c	r as a conseq	uence of):								
cate be executed physician and the burial-transit		dical		d										
		Neg	IF FEMALE:											
death certific s attending p		nysician/me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 Pregna	rth 2 ☐ Feta ant at time of o	aldeath 3[Ectopic pregnand Other (specify)	су				ate of deli		Year
Los, T.C. Laires that the designed by the additional defends of the control of th		S/u	9 ☐ Unknown	9 □ Unkno	wn									
res that signed be de		b F	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the ui	nderlying cause giv	ven in Par	t I.		tobacco use cor			
w require been s		ered								10		3 ☐ Pro		Unknown
e la has		Completed								24a. Was auto perfo 1 □ Yes		prior to c death?	topsy findings completion of c 2 □No	available ause of
vicari ilclan: Th certificate ector, pag	à	Re	25. Was case referred to medical examiner?	11it-l			To:		ce of Death	h (Check only o				
Phys ral dir	- 15	0	1 ☐ Yes 250 No 27. Manner of Death	Hospital: 12 Ir		ER/Outpatier 28b. Time of				· · · · · · · · · · · · · · · · · · ·	idence 6 □Ot		cify)	
dlng Affer			Natural 5 Pending 2 Accident investiga	(Month	n, Day, Year)	Injury	Wor	rk?]Yes 2[zou, Describe	how injury occu	rred		
Atten ar dear ector by the		Certification:	3 Suicide 6 Could no	t be 28e, Place of	of Injury - At h	ome, farm, str	eet, factory, office				Street and Num	ber or Ru	ral Route Nun	ıber,
pltal or urs afte eral Dir											wn, State)			
To the Hospital or Attending Phymithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or		Medical	29a. Certifier (Check only one) Certifying Certifying Certifying	Physician: To the xaminer: On the ba and mann	sis of examina	ation and/or in	occurred at the t vestigation, in my	opinion, d	and place, leath occur	and due to the red at the time,	e cause(s) and n , date and place	nanner as , and due	to the cause(s	3)
with to the	:	Σ	29b. Signature and title of certifier		_		29c. Licens	se numbe		-,	29d. Date sign			
-	5		Splan			,	1000	65	44	8	81	11/5	28	
12+1			30. Name and address of person w	HNANII	ND 7:	503 5	Print) URRAT	TSRI	D; C	LINTO	N MI) 2	2073	5
: Regi	State stra		31. Date filed (Month, Day, Year) AUG 1 3 20	108 July 22. Re	gistrar's Signa	ature	82							
		_		- 100	-	-								

DHMH 17 Rev 1/2001

08-06070 Robert Lewandows	1	Please Type or Print in Black Indelible Ink. En State of Maryland / Department of Health For State equistrar Certificate of Death	and Mental Hygiene		200	8 2601
Physician Medical Examine	1	I. Decedent's Name (First, Middle,Last) Robert Lewandowski	Monti	of Death	ay Year	3. Time of Death 2014 hrs
Funeral Director		Johns Hopkins Bayview Medical Center Baltimo Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months	wn, or Location of Death ore 1 Year If Under 24Hrs. 8. Date Days Hours Min.	e of Birth(I	4c. County of Death N/A MM/DD/YYYY 9. Birth Foreign	atm.()
any	_	220-62-27/3 1 X M 2 F 54 Yrs.	Ma	y 8,1	1954	MD 10d. Inside City Limits
the Maryland a or 28a-f show a tifled at once.		Maryland Baltimore Du 10e. Street and Number 10f. Zip (nda1k	10g.	Citizen of What Count	1 Yes 2 X No
with the Ma with the Ma ns 23a or 28 be notified a		7315 Wenig Avenue	21222		United S	
Aer death with ", or items 23 er must be no			t of Hispanic Origin? (Specify Ye Cuban, Mexican, Puerto Rican, e		14. Race - Americ White, etc. Specify: Wh	an Indian, Black, ite
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other fraumatic event, the Medical Examiner must be notified at once.	nalaidiiion	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	ccupation (Give kind of work doning life. DO NOT use retired)	11	6b. Kind of Business/In Shipping	,
215-0036 be filed within 7 nntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) Robert J. Lewandowski	18.Mother's Name (First, M			
ID 212 2 should be and Ment 27 is mark matic ever			(Street and Number or Rural Ro	ite Numbe	er, City or Town, State,	
Baltimore, MD oemit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati	1	20a. Method of Disposition 20b. Place of Disposition (Nam. 1 Burial 2 X Cremation 3 Removal from State crematory or other place)	of cemetery, Date ice Corp. 8/13/		Towson, M	
Balti permit. Departu Importu injury o		21. Signature of Funeral Service Licensee 22. Name and A Duda 7922	ddress of Facility Ruck Funeral Ho Vise Ave. Dund	alk,	Maryland 2	1222
Physician /Medical xaminer	ı	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of failure. List buy one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
nted d ansit	Xa Xa Xa	C. Due to (or as a consequence of): d.				
be execute sician and urrial - tran		X UNPENDED	882 8/20/08 TT			
I Records, P.O. Box 68760, at The law requires that the death certificate be executed rifficate has been signed by the attending physician and or, page 2 should be detached for use as the burial - trans		FEMALE: 3b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delivery Month D.	ay Year
i, P.O. E ires that the signed by the detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying Cocaine use	giron mirani		acco use contribute to t	
II Records, P.O. In: The law requires that the rificate has been signed by for, page 2 should be detach.	Completed		24	a. Was an autopsy perform	prior to co ed? death?	opsy findings available ompletion of cause of
rifficate for, pag	3 -	25. Was case referred to medical 2	Death (Check only one	Yes 2	✓ No 1 Yes	3 2 No

Medical Certification: To Be

examiner? 1 ✓ Yes

27. Manner of Death

Division of Vital Re
To the Hospital or Attending Physician: Th
within 24 hours after death.
To the Funeral Director: After this certificat
completely filled in by the funeral director, pa

7. Manner of Dea	th	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural	5 Pending	(Month, Day,Year)		1 Yes 2 No	
2 Accident	Investigation				
3 Suicide	6 Could not be	28e. Place of Injury - At h	ome, farm, street, factor	ry, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
4 Homicide	determined	(Specify)			
9a. Certifier 1	Certifying Physician	: To the best of my knowled	ge, death occurred at the	ne time, date and place, and	d due to the cause(s) and manner as stated.
one) 2 🗸	Medical Examiner:0	n the basis of examination a	nd/or investigation, in n	ny opinion, death occurred	at the time, date and place, and due to the cause(s)

DOA

30. Name and address of person who completed cause of death (Item 23a)

Hospital: 1

and manner stated.

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Other₄

Nursing Home 5

Other:

29d. Date signed (Month, Day, Year)

August 9, 2008

Residence 6

Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) AUG 13

29b. Signature and title of certifier

Inpatient 2 V ER/Outpatient 3

28b. Time of Injury

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year MANNS **Physician** YOSEPH 6:49 AUGUST 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NORTHWEST RANDALLSTOWN HOSPITALIST 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours M 2□F 220-30-239 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Items 23a or 28a-f show ner must be notifled at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 6 ģ 3 Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manspertation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BUITU. NO 21208 Krenda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARYCAND 1 ☑Burial 2 □ Cremation 3 □ Removal from State 08-18-08 4 □ Donation 5 □ Other (Specify) TARRIUM HODEST 22. Name and Address of Facility | W2 | 21. Signature of Funeral Service Licenses 4600 UBERRY MP 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** INFECTION URINARY TRAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bus to for as a consequence of Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIFFICILE CLOSTRIDIUM 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 1□ Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 224325

State Registrar

DHMH 17 Rev 1/2001

SHOLOLD COURT ROAD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

NORTHWEST HOSPITAL

31. Date filed (Month, Day, Year)

AUG

MITTCEA

TODOR

PANDALLSTOWN

2008

21133

AUGUST

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MILDRED FRANCES MONESKI AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BACTIMONE
If Under 1 Year | If Under 24 Hrs. JOHNS HORLING BANTEW MEDICAL CENTED

E Social Societiv Number

E Sex 7, Age (In vis. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) FEB. 14,1922 MARYLAND 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Min. Months 1 □ M 2 💢 F 86 214-12-8329 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experimer must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21224 430 BONSAL STREET U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: WHITE Completed by 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygiene. HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic enones. **JOSEPH** REHAK SOPHIA SOKUP 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARIA WELKER/ DAUGHTER 405 JOPLIN STREET, BALTIMORE, MARYLAND 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS CEM. 8/13/08 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 21. Signature of Fu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YEARS HYPERITURSION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 TEARS ATRIAL FIBRILIATION Sequentially list conditions Examiner n any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed 24EARS attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) the detached signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown BOWEL SYNDRAME Completed 24b. Were autopsy findings available prior to completion of cause of death? ANKIETY cate has l , page 2 s autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No DEPRESSION • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 200

Registrar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician McNair 2003 /Medical Ruby 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number Baltimore () If Under 1 Year | If Under Hospital Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🔀 F 61 436-78-7909 Οľ 47 LA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be multified at Y☐Yes 2☐No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 U.S.A. 3922 Maine Ave Apt A Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or if 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: Specify Š Black 3 Widowed Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juanita Brumfield David McNair ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3922 Maine Ave, Baltimore, Md 21207 Sharon Bond-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 GBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 8/16/08 Woodlawn, Md 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West Stanature of Funeral Service Licensee March F/H West
4300 Wabash Ave, Baltimo

23a. Party. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Baltimore, Md Approximate Interval Between Onset and Death Irim late Cause (Final Physician Due to (or as a consequence of): se or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ þe 2 No 3 Probably 4 Unknown 1 ☐ Yes cances Metastatic DEPUST Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed?

1 □ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this within 24 hours after death,

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 2008

Registrar
DHMH 17 Rev 1/2001

State

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Hospital of Baltimore

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Carlos

31. Date filed (Month, Day, Year) AUG 13

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 26020 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 9 2008 12:10 PM August William Lynn Macewicz 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Montgomery Village Montgomery Montgomery Village Health Care Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Days Hours Months 1⊠M 2□ F Yrs June 20, 1954 New Jersey 54 212-64-7200 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1. ☐ Yes 2 ☐ No Germantown Maryland Montgomery 10g. Citizen of What Country 10f. Zin Code 10e. Street and Number 20874 United States 4 Duck Pond Court 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 21亿 No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Baggage Specialist Airline Security 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Laura White John C. Macewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Germantown, Maryland 20874 4 Duck Pond Court Donna J. Wilson-Macewicz / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 15 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear (failure) List only one cause on each line. Approximate Interval Between Onset and Death a gdranced chronic Liver Discar Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Civinosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last epato Ren Due to (or as a consequence of): encephalo 1ctob-11c 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "neturel", or Items 23a or 28a-1 show any Injury or other traumatic event.

altimore, Maryland 21215-0020

Examine Physician/Medical ۾ Completed

physician and s the burial-transit attending ph been signed by the should be detached Certification: To Be

The law requires that the death certificate be executed eral Director: After this certificate has tilled in by the funeral director, page 2 s or Attanding Physiclan: death. To the Hospital of within 24 hours a To the Funeral Completely filled in the form of the filled in t

Division of Vital Records, P.O. Box 68760,

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State Registrar

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 □ N 2 000 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DAILES WD

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doctori Dive Germantour MD 20874 19529 anti

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August Naomi 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard County General Hosp. Columbia Howard Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 🖵 F 215-16-9821 85 25,1922 Maryland Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1711x1o Maryland Howard Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2233 Merion Pond 21163 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXI If Yes, Give Year or Dates: 1 Never Married 2 Married 2XMVo 1 ☐ Yes 200No Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Frederick Krause Marie Anna Reuter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Murphy (Son) 2233 Merion Road Woodstock, Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition nlace) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 8/11/2008 Baltimore, Maryland Donation 5 ☐ Other (Specify) 21. Signal не of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 Part I Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an 1□ Yes 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

Examiner Hospital or Attending Physician: he law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician certificale this After t Director: in by

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina once.

Physician /Medical

Baltimore, Maryland 21215-0036

Societiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

Kanesh

and

29c. License number D306H August 8 2008

State Registrar

Medi

31. Date filed (Month, Day, Year) 2008 **AUG 13**

Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMESH Sabapathi 201-105 Back Rwy Weck Road Ballimer Maylan 21221 Registrar's Signature

and manner stated.

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 2008 ea **Physician** AUGUST 5:15p GRAYSON W. MARSHALL, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 1014 BRANTLEY AVE. Date of Birth (Month, Day, Year) 5-9-1939 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Min. 1 X M 2 □ F Months Days Hours MARY LAND 69 217-34-4658 Director Usual Residence of Decedent Od. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√Yes 2□No Director BALTIMORE N/A MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 1014 BRANTLEY AVE. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 X Yes 2 □ No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-SOCIAL SECURITY COMPUTER ANALYST permit. Pages 1 and 2 should be filed : Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED LINDSAY GRAYSON W. MARSHALL, SR. ည 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Petationship (Type. Print) 11815 BLUE FEBRUARY WAY COLUMBIA, MARYLAND 21044 ROSALYN MARSHALL (DAUGHTER) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 Cremation ARBUTUS MEMORIAL PARK 8-13-2008 BALTIMORE, MARYLAND 5 ☐ Other (Specify) 4 Donation D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Funeral Service Licensee 21. Signature o 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. E ter the disease, or complications that caused the slock, it heart failure. List only one cause on each line. Immedi te dause (Final disease of condition resulting in death) **Physician** inchour /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to inductive cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No ned by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably nknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performe has 2 No certificate 1 ☐ Yes 1 ☐ Yes : After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only onle, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Dr ath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

completely

29b. Signature and title of certifier

2008

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mollie

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32. Registrar's Signature

and manner stated.

RM 8011 Manument

31. Date filed (Month, Day, Year) Registrar

Medical

29a. Certifier

(Check only one)

atal	lie Reeves		State	of Maryland / De	partment of h	lealth and	Mental H	lygiene		
			- For State	C	ertificate of L	Death		Reg.	No. 20	08 2602
	Physicia		Decedent's Name (First, Middle,Last		,			Date of Death Month D	ay_ Year	3. Time of Death 1628 hrs
1	ור Examir		NATALIE	KEEVES	1.5	. City, Town, or Lo	nation of Deat	Month D August 7, 20	4c. County of Dea	<u> </u>
			4a. Facility Name (if not institution, give Sinai Hospital	e street and number)		Baltimore	Callon or Deal	41	10.000,	
	Europe	•	5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24Hr	rs. 8. Date of Birth(MM/DD/YYYY) 9. B	irthplace (State or
	Funeral Director		6	M 2XF	Yrs.	Months Days	Hours Mi	n. Nevembe	C 1.1961 Fore	ountry) Mi)
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	ану		10a. State 10b. County	10c. (City, Town or Location	1				10d. Inside City Limits 1 X Yes 2 No
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5	Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code	115	109	. Citizen of What Co	untry?
0	death with the Maryland or items 23a or 28a-f sho must be notified at once		2307 DUALA F		pt. 2B	<u>م ۱</u>	412	Consider Manage No.	US J	erican Indian, Black,
1	th with	Funeral	11. Marital Status1 Never Married2 Married	12. Was Decedent Ever Armed Forces?	If Yes	Decedent of Hisp. s, specify Cuban,		Specify Yes or No- to Rican, etc.)	White, etc.	encari indian, black,
	er deal	큔		1 Yes 2 X	10	res 2 No	specify:		Specify: P	JACK
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	036 ithin ne. r that	d m	11		l	chet			Consper	College
	215-0036 se filed within 72 hours after that Hygiene. ked other than "naturat", ent, the Medical Examiner.		17. Father's Name (First, Middle, Last	1		1	8.Mother's Nar	me (First, Middle, Ma	NE/60N	
	e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	Be	19a. Informant's Name/Relationship (1		19h. Mailing	Address (Street	and Number o	or Rural Route Numb	er, City or Town, Sta	ate, Zip Code)
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	e, M l and 2 Health item 2	Ì	20a. Method of Disposition		20b. Place of Disposit crematory or other	ion (Name of cem		Date	20c. Location - City	or Town, State
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			4 Donation 5 Other Specify 21. Signature of Funeral Service Licer	nsee	22. No	me and Address		343	b W Forest	PANK AME.
	Balt permit. Departi Import injury		of Hay O. Brong		5ers	10. DIEH 3.	Farana .	Perairy 3	Od-ofla	
	hysician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the cach line.	leath. Do not enter th	e mode of dying, s	such as cardia	c or respiratory arre	st, snock, or near	Approximate Interval Between Onset and Death
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			or condition resulting in death)	Due to (or as a consequent	nce of):					
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):					
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque	nce of):					
lij	gansit de 'Q	ŭ	events resulting in death) Last	,		_				
•	Box 68760, ce death certificate be executed the attending physician and ned for use as the burial - transit	dical	X UNPENDED	AMENDED 23a,	PII,2/,per	ME,g882	8/29/0	8 TT		
	68760, certificate be nding physicise as the buri	Sec.	IF FEMALE:	23c. If yes, outcome of	pregnancy	- [11-12-11-1	23d. Date of deli	
	687 ertific iding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time		al death 3 [ner (Specify)	Ectopic pre	gnancy	Month	Day Year
	Box 68760, e death certificate but the attending physical for use as the but	Physician/Me	1 Yes 2 No 9 V Unknow	- Laure	5 Ott	ier (Specily)				
	O. E at the of the tached	표	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	1		e to the cause of death?
	Division of Vital Records, P.O. I rate of tetranding Physician: The law requires that the rate death. 31 Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	d by	Post-inflamma	itory valve o	lisease			_		Probably 4 V Unknown
	rds v requi s been should	lete						24a. Was a autop	sy prior	e autopsy findings available to completion of cause of
	ecc he lav ate has age 2 :	Completed						perfor		
	an: T ertificator, p	BeC	25. Was case referred to medical			26.Place	of Death (Che			
	Vita hysici this c	일	examiner? 1 ✓ Yes 2 No		2 ✓ ER/Outpatient		Other Nu		Residence 6 C	Other:
	ing P After funera	=	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of I	· ·	Yes 2 No	l l	low injury december	
	Sion Attend death. ector:	jġ.	2 Accident Pending Investiga	ation	- At home, farm, stre			1	Street and Number of	r Rural Route Number, City
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	Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dawithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Ce		To the heat of my kn	owledge, death occur	red at the time, d	ate and place,	and due to the caus	e(s) and manner as	stated.
	the I	Medical	(Check only one) 2 Medical Examin	er: On the basis of examina and manner stated	ation and/or investiga	tion, in my opinior	n, death occurr	red at the time, date	and place, and due	to the cause(s)
1	To To	Me	29b. Signature and title of certifier	(29c. Licens	se number			(Month, Day, Year)
	^\		high	o'm's		O.C.	M.E.		August 8, 200)8
	25 cg		30. Name and address of person wh		h (Item 23a)		MD 04001			
	OF 1º			Medical Examiner	111 Penn Stree	et, Baltimore,	MD 21201			
	Regi	State	31. Date filed (Months Day, Year) 2	36 Registrar's	Signature Char	le				
	N-Sill	-116		EL.						

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		A	mend 4a, perMD, g88	Type or Pring 8/13/08 State of Management of	nt in Bia 3 TT aryland	Ack Ind	delible Ink.	Ensure A	ii Copies Mental Hy	Are Leg	ible.	20021
			State Amend #2,29d, Registrar		02 0/1	3/eer	tificate of	Death	2 Date of De		08	2 0 U 2 4
	Physici /Medic		1. Decedent's Name (First, Middle, Las Amanda Virg	inia Ric					Month AVG-US	Day	2008	9:44 PM
	Examin		4a. Facility Name (If not institution, give	Street and number) Agnes Hos		t		LTIM		4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. Se		93	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Oct • 2	ly, Year)	Cou	pplace (State or Foreign intry) ryland
	D		Usual Residence of Decedent		100 City 7							10d. Inside City Limits
	show	2	10a. State 10b. County MD Baltin	oro	10c. City, T		sville					1 ☐ Yes XX No
	28a-f	ect	10e. Street and Number	OLC		acon	10f. Zip Code			10g. Citizen of	f What Cou	untry?
	death with the Maryland ims 23a or 28a-f show	Funeral Director	106 S. Hilltop	Rđ.				21228		U	.S.A	
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of H	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No)- 14. Ra	ace - Amer ack, White	ican Indian,
21215-0036	hours after death with the Marylan tural', or frems 23a or 28a-f show at Executer mast be notified at	þ	1 ☐ Never Married 2 ☐ Married XXVidowed 4 ☐ Divorced	1 Yes XX If Yes, Give Year or Dates:			1 ☐ Yes X2X No		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Spec		hite
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	1	(Give	ient's Usual Occup kind of work done	during most of wor	king	16b. Kind of	Business/I	ndustry
121	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retire omemake	*		70	wn Ho	ome
	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			11	Omemare	18. Mother's Nan	ne (First, Middle,			
au	d be ental ked o c eve	To Be	Thomas Biden					Ann	ie Nar	er		
Maryland	shou a mar umat	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street	and Number or Ru			n, State, Z	ip Code)
	and 2 paith a 27 to er tra		Carol L. Bowers	/ Daught				top Rd.				
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, ILE M. ADGE.	1	20a. Method of Disposition 20a. Method of Disposition Cremation 3	Removal from State	20b. Plac	e of Dispo	sition (Name of patory or other pla Veter	ce)	Date	20c. Location	1 - City or 1	Fown, State
ij	ment tant: i		4 □ Donation 8 □ Other (Specify		Mary	Ceme	etery	08/				1s, MD
3ail	Departimpor important in portant		21. Signature of Funeral Service Licen	6/								apel P.A. 1s,MD21117
	-		23a. Part1. Enter the disease, or comp	olications that cause	d the death.						MIL	Approximate
. 8			shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.			INFA				Interval Between Onset and Death
9	Physician /Medical		disease or condition resulting in death)	u	a consequer		DITIC	1101-14	20//0/	~		5 HOUR
36.	Examiner	Ų ·										
	D ti	iner	Sayuentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequer	nce of):						
	and I-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):					-	
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9289	tificate be ig physici as the bu	edic		d								
.O. Box	ne death cer the attendir thed for use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 DLive birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3[]Ectopic pregnanc] Other (specify) _	у			Oate of deli Month	ivery Day Year
Q	res that the igned by be detact	by Ph	Part II. Other significant conditions of	ontributing to death t	but not resulti	ng in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
rds	quires an sign uld be	ed b	ALZHIE.	MER'	s I	SEM	ENTI	A	1 🗆	Yes 2□No	3 🗌 Pro	obably 4 Unknown
Vital Records,	he law requ e has been age 2 shoult	Completed	<u> </u>							ormed?	b. Were au prior to death? 1 \sum Yes	topsy findings available completion of cause of
ta		0	25. Was case referred to medical					26. Place of De	1 Yes		1 1 1 42	20140
<u></u>	× 5 0	ToB	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpati	ent 2 EF	R/Outpatier	nt 30 DOA Ot	her: 4 🗆 Nursing h	lome 5 ☐ Res	idence 6 🗆 C	other (Spe	cify)
0	ding Ph J. After th tuneral	uo:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 29 ay Year)	8b. Time o Injury	Wo		28d. Describe	how injury occ	urred	
sio	Attending it death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not b	,]Yes 2 □No	20f Location	(Stroot and Nu	mbor or Ri	ural Route Number,
Division of	- 9	Certification;	4 Homicide determined	286. Place of in	itc. (Specify)	e, tarm, st	reet, factory, office			wn, State)	TIDE! OF TIL	ar noble vulliber,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical		ysician: To the best niner: On the basis of and manner s								
	To th withir To th comp	Me	29b. Signature and title of certifier.	1.4	60		29c. Licen	se number		29d. Date sig	ned (Mont	h, Day, Year) 2008
			/ Clale	ites	M	2	Do	05/86	55	AUGU	57	7,2007
6	B		29b. Signature and title of certifier. 30. Name and address of person who CHMLRS C 31. Date filed (Month, Day, Year)	completed cause of	death (Item 2	За) (Туре,	Print)	HUSPIT	Mc	BALT	im.	ine ma
in a	Sta		31. Date filed (Month, Day, Year)	2. Regist	trar's Signatur	re Anes	de)				-	
	Regist	rar	AUG 1 2 200	o seems	, ,,,	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2008 3:15 AM M Frances August 12 Rea /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9050 Gracious End Court Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1941 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F Hours Maryland 217-38-3454 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural," or items 23a or any injury or other traumatic event, the Medical Examiner must be r 9050 Gracious End Court 21046 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harrison Smith Blanche Marie Barth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Rea / Husband 9050 Gracious End Court Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 08/12/2008 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service License 5311 Edmondson Avenue Baltimore, Maryland 21229 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ANCE **Physician** 40 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has autopsy performe funeral director, To Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Affer Injury 1 Natural 5 ☐ Pending investigation ours after death. reral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar LUKY ETERO 31. Date filed (Month, Day, Year) 32 AUG 1 3 2008

30. Name and address of person who completed

32 Negistrar's Signature

cause of de

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eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5, perFH, G882, 8/19/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ST **Physician** V. Robinson 200 Carolyn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5250cial Security Number 212-42-9832 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 🛠 🗆 F 62 Director 02 06 MD 46 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at 1 X Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 U.S.A. 605 Allendale Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes . 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" near in item 27 is marked other than "natural" near any injury or other fraumatic. XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black <u>Ş</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th grade College (1-4or 5+) Phlebotomist na Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Columbus Robinson Margaret Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Marydell Road, Baltimore, Md Charae Johnson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, Md 8/12/08 Arbutus Memorial ature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, ema 21215 Baltimore, 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immy diate Cause (Final Due to (or s a consequence of): seavs **Physician** dis ase or condition r sulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? monam 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death

1 ☐ Yes 2 ☐ No 24a. Was an has 2☐No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 phopatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a

To the Funeral I 1. Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) GOOCATON AUE BALTIMORE MODIZES EFFR MO EY EL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 13 2008 Registrar Gosale Continue.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 26027 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** : 20 vee. tugus 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore izabeth Center Wing If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs. 214-18-5110 Director 88 7,1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Yes 2 □ No Director Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 1610 N. Bentalou Street , or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 ☐ Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Sumame)
Lillian Evans 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental William Joseph Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3414 Powhatan Ave Baltimore, Maryland 21216 19a. Informant's Name/Relationship (Type, Print) If item 27 Is Ruth Taft/ Sister of Health other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H.
Importent: If iter
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn, Maryland Cedar Hill Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ameral Sorvice Licena 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Enter the digease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emen e ins /Medical Due to (or as a consequence of): Examiner PIZUVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No en sion 3 ☐ Probably 4 ☐ Unknown vascular acciden 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ٥ Manner of Death
1X Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation s after death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ro the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008

Registrar

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30. Name and address of person who propleted cause of death (Item 23,2) (Type, Print)

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			For State Registrar	State of Marylan				ealth ar D <i>eath</i>	nd Mer		iene g. No.	008	26	028
	Physici		Decedent's Name (First, Middle, Last) Richard	Α.	Stei	iner				Date of Death Month Ugust	Day	Year 2008	3. Time of 2:20	
	/Medic Examin		4a. Facility Name (If not institution, give s Fairfield Nur	treet and number)		4b. City	ownsv	Location of	Death		4c. C	ounty of Deat	undel	
6	Funeral Director		5. Social Security Number 6. Sex 145-14-7115	M 2□ F 7. Age (In yrs. 82	last birthday) Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, eb. 2,			hplace (State untry) Jerse	
C. C	8a-f ehow	ector	10a. State 10b. County Hawaii Honolulu		y, Town or Lo Vaiane						0-00:	411111111111111111111111111111111111111		City Limits s 2 \(\overline{\pi} \) No
4	23a or 2	Funeral Director	84-770 Kili Dr., A			9	6792		-0.454		USA	en of What Co		
5-0036	rature!; or iteme 23a or 28a-f ehow	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	2. Was Decedent Ever in U Armed Forces? 1 [X]Yes 2 ☐ No If Yes, Give Year or Dates: WW		_		spanic Origii n, Mexican, l Specify:	n ? (Specin) Puerto Ric	y Yes or No- an, etc.)		Black, White		
21215-0036	ene. than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12			kind of wi DO NOT i	ork done d use retired	ation furing most of tment				d of Business/		
ם ייי	otal Hygi	To Be Co	17. Father's Name (First, Middle, Last) Edward	Steiner			Бери	18. Mother		irst, Middle, M	Maiden S			
, Mary	thand 7 is m treum		19a. Informant's Name/Relationship (Ty) Brian Steiner (Son)	84-77	70 Ki	li Dr		t. 15	640, Wa	iana	Town, State, 2 ie, HI	96792	
Baltimore,	perrint. Fages I am Department of Heali Important: If Item 2 eny injury or other 2002.		20a. Method of Disposition 1 Burial 2 Cermation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	amoval from State Bai	Place of Dispo Profile Condor Loudor	Par Par 2. Name a	MATOI k nd Addres	8 s of Facility		B lon Par	alti k Fu	more, more, meral MD 21	Maryla Home	nd
E	hysician /Medical examiner	niner	23a. Lenter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		quence of):	1	de of dying		ardiac or re	espiratory arre	est,		Approxim. Interval B Onset and	etween
Box 68/60,	ueatt centilizate be executed eatlending physician and ed for use as the burial-transit	Physician/Medical Examin	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consection of pregnum of pr	ancy]Ectopic p	pregnancy				2	3d. Date of de Month	livery Day	Year
P.O.	of the desire the a	Physic	1 Yes 2 No 9 Unknown	4⊟Pregnant at time of o		Other (s								f dank?
ords,	ins law requires trat the ste has been signed by th page 2 should be detache	þ	Dementia, De	tributing to death but not res	sulting in the c	inderlying	cause give	en in Part I.	_	1 🗆 Y		e contribute to		Unknown
H Rec		Completed		V						24a. Was a autops perform	med?	24b. Were a prior to death? 1 ☐ Yes	utopsy finding completion of 2 2 No	s available cause of
	this certificeteral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatie		Oth	or .		Check only on		Clother (See	arf d	
Division of Vital Records,	Affer I		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Worl		280	d. Describe h		Other (Spe	Кпуј	
Divis	s after death al Director: A ed in by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, facto	ry, office		281	f. Location (Si City or Town		Number or R	ural Route Nu	ımber,
	within 24 hours after or yet the Funeral Director completely filled in the completely filled in	edicai	(Check only 2 Medical Examination)	ician: To the best of my known to the basis of examination and manner stated.	owledge, deal ation and/or in	vestigatio	n, in my o	pinion, death	place, and occurred	at the time, d	ate and	place, and du	e to the cause	
	To	M	29b. Signature and title of contrile	MD		Ī	38 38	958			8/:	signed (Mon		
) Sta	ite	30. Name and address of person who co	mpleted cause of death (Itel	28 G	Print). UM Ged	Ht	ghway	6 S1	w of	en d	Burni	e MI	2106

Please Type or Print in Black Indelible Ink Property All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 26029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Alexander Sampson 08 Ó8 3:58p.M /Medical Henry 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3213 Burleith Ave Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 02 9. Birthplace (State or Foreign **Funeral** Year) Days Hours Min. Months 1 JM 2 □ F 80_79 28 Director MD 216-24-9226 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examinar must be notified at Director MD NA Baltimore 1X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21215 U.S.A. 3213 Burleith Ave 23a Funeral 72 hours after death items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 1 ☐ Yes 2 ☐ No Specify: ģ Specify: Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Disc Jockey Radio Stations na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rachael Sewell ဂ James Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Burleith Ave, Baltimore, Md 21215 Lucinda Sampson-Wife permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 8/15/08 Donation 5 ☐ Other (Specify) Woodlawn, Md 21. Siapate of Funeral Service License 22. Name and Address of Facility
MarchF/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lime.

Immediate Cause (Final disease constitution) 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** Failure Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): aftending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) the 1 □Yes 2 □No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 - No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner's Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Bank house

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Kenwood

31. Date filed (Month, Day, Year)

D 31285

21206

8/11/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 26030 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Skinner 08 08 2008 1:45p. Tola Hutchinson 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Future Care Nursing Home Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Days Hours Min 579-26-8273 84 09 10 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Eutaw Place Apt 122 21217 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: **¾**☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Waitress Restaurant na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Hutchinson Dorcus Rafford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 19a. Informant's Name/Relationship (Type. Print) 501 Dolphin Street Apt 1506, Baltimore, Md Iola Cooper-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Crematory Inc 8/12/08 Baltimore, Md Metro of Funeral Service Licens 22. Name and Address of Facility March F/H West 21 Si 4300 Wabash Ave, Baltimore, Md 21215 Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart dalure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 808 rowe Due to (or as consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a co Accident Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Box 68760, P.0. of Vital Records, the Hospital or Attending Physician: Division

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evaminer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or items or other traumatic event, Itw Medical Evan not must be a

Department of Important: If Its any injury or o

Physician

/Medical

Examiner

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-burialphysician s the burial

attending pl

ate has been signed by the page 2 should be detached

After this certificate has

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Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of gertifier

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ဥ

the Maryland

/Medical

within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur ٥

State Registrar

+SHMI MI)

MD

29c. License number D31464

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 8/11/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, \$21 N. ENTAN ST Ente 300 13ALTMORE MI) 2/201

31. Date filed (Month, Day, Year)

and manner stated

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Grace Schulten 10, 2008 8:18 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8800 Walther Blvd Apt. Baltimore 3012 Parkville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/3/1921 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 014-34-0493 86 Director Hawaii Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examinar must be notified at Baltimore Parkville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 3012 21234 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: White ģ 3 X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private Education Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carlos Brewer Grace Moore and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11012 Old Landing Rd, Kingsville, MD, 21087 Thomas Schulten/son Health em 27 i permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. Baltimore. Pages 1 / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 8/12/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Towson, MD,21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** 210 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner wwww Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death Day 5 Other (specify) been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? After this certificate funeral director, pag 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specity) Hospital: 1 Yes 2 → No 2 ER/Outpatient 3 DOA ဥ 1 | Inpatient Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending ours after death.

neral Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Blud (XIV Karen 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{p}^{M} 2008 AUG 7, 305 Ann Leona Spranger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death Examiner Montgomery Rockville 12805 Spring Dr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ XF NOV 13. 1921 Michigan Director 375-12-9659 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show iner must be notlifled at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 United States 410 Torrington Pl. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. item 27 is marked other than "natural", or item other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by 3 ₩idowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within; th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Karl A. Alder Leona M. Dunslager P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum Annette C. Alder/Daughter 618 Bonifant St. Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Inc. 8/8/2008 22. Name and Address of Facility
Rapp Funeral & Cremation Services 1400382 Rapp Funeral & Cremation Ser 933 Gist Ave., Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Alzheimer's Disease 5 yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed ysician and e burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical phys s the ding IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9∏Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ♠ Yo 24a. Was an Atrial Fibrillation autopsy performed? Yes 2 XNo has certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 ☐ Homicide To the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22309 August 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8712 Dogwood Ave., Silver Spring, MD 20910 Phillip Poth, Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar AUG 13

DHMH 17 Rev 1/2001

08-05977

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Physician	/ R	tegistrar 1. Decedent's Name	e (First, Middle,	Last)	007	inoate o	Death				Date of Death	. No. Day	Year	3. Time	of Death	
M 'Examine	rľ	Kenneth					41. 69. T-		antion of I	_ A	ugust 4, 2	800	ounty of Deat		2 hrs	
	1	4a. Facility Name (if Johns Hopk		give street and number	r)		4b. City, To		ocation or i	Deam		40.0	ounty of Deat			
Funeral Director		5. Social Security N 217-17-0	1525	7. A 1 M 2 F		ast birthday) Yr	If Under Months	_	If Under : Hours	24Hrs. 8 Min.	. Date of Birth 12/04,	(MM/DD /197	73 Forei	rthplace (gn buntry) M	State or D	
any	_	Usual Residence of 10a. State	Decedent 10b. County		10c, City,	Town or Loca	tion					_		10d. lns	side City Limits	
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ith the Maryland 528 or 28a-f show notified at once.		10e. Street and Nur 2312 Tar		Lane Apt	. A		10f. Zip C 2123					. S . A	n of What Cou	intry?		
er death w	Laue	11. Marital Status 1 X Never Marrie 3 Widowed		12. Was Deceder Armed Forces 1 Yes rced If Yes Give Year		lf '	as Deceden Yes, specify	Cuban, I			y Yes or No- an, etc.)		Race - Ame White, etc. Decify: Wh	ite	an, Black,	
hours a 'natura	ea b			fy only highest grade co		16a. Decede	ent's Usual C most of work									
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "injury or other traumatic event, the Medical	Be Con	17. Father's Name	(First, Middle, L Slav	in				S	heil	La B	,					
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iore, l ges 1 and t of Heali t of Heali ti fitem		20a. Method of Dis		3 Removal from S	State	Place of Dispo crematory or o	other place)		· 1		ate		cation - City o			
Baltimo permit. Page Department of Important: injury or otl		4 Donation 5	Other Spe	ecify:	Ch	esape							ltsvi			
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hysician ∥edical cxaminer		23a. Part Enter the failure. List on Immediate Cause (or condition resulting)	ly one cause o Final disease	complications that cause on each line. a Heroin i Due to (or as a cor	ntoxi	cation					espiratory arre	st, shock	k, or heart	Appr Betw	oximate Interval reen Onset and Death	
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ath certificate attending physor use as the b	sician/Me	IF FEMALE: 23b. Was decedent past 12 months	s?	4 Pregnant	at time of d	2 1	Fetal death Other (Spec	3	Ectopic	pregnanc	y		Date of delive	ery Day	Year	
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of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should t	Completed									_	24a. Was a autop perfor	sy med?	prior t death	o complet ?	ndings available ion of cause of	
Vital Rec	ωl	25. Was case refer	rred to medical						of Death (Check on	y one)					
F Vite	9 2	examiner? 1 ✓ Yes	2 No		atient 2	ER/Outpatie	ent 3 🗸 D		Other ₄	Nursing I	Home 5	Residen		ner:		
on of \nding Phy. th. r: After the funeral	<u>ë</u>	27. Manner of Dea 1 Natural	5 Pend	28a. Date of I (Month, Da ing Fnd 8/4	y,Year)	Fnd 9:			es 2 X		ınk	ion inju	, 000000			
Division tall or Attending and after death. "all Director: A led in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	Inves	tigation 28e. Place of	f Injury - At h	in a g	reet, factory,	office bu	uilding, etc	2. 2i	8f. Location (Sor Town, Sor Town, Sor Town)	Street and tate)	Number or	Rural Rou	ite Number, City	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifier 29a. Certifier 29a. Certifier 3 Certifier 4 Certifier 3 Certifier 4 Certifier 3 Certifier 4 Certifier 3 Certifi								ue to the caus	e(s) and	manner as s	tated.	- 20			
	Me	29b. Signature and	title of certifie	г	,		290		e number	29d. Date signed (Month, Day, Year)					y, Year)	
V		his	w,	MP				O.C.N	vi.E.		August 5, 2008					
0		30. Name and add		who completed cause on Medical Examir		_{m 23a)} 1 Penn Str	eet, Baltii	nore, f	MD 212	01						
Sta	ite	31. Date filed (Mor		2008 3 Regis	strar's Signa	Aye do	use									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 24a,25,27 per dr.,982,08/13/18/400 of Death

Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Пау Physician 2008 JUX HARLINE Simon 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BARMARE 8. Date of Birth (Month, Day, Apr 9, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex **Funeral** Min Months Days Hours 1 □ M 2 🖺 F 216-50-1989 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1.☐Yes 2☐No Director MD Brooklyn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21225 USA 336 W. Arundel Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🏋 No altimore, Maryland 21215-0036 Specify Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk æ ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 21225 3001 S. Hanover Street Baltimore, MD Harbor Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 natur of Funeral Arvice Licensee

Ranald S. Waar / Director 655 W. Baltimore Street enna 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician NON-SMALL CETT LINE GANCER METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duo to (or as a consequence of) Physician/Medical Examiner the burial-tran The law requires that the death certificate be execu Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HERRIGIANIA 24a. Was an performed? Yes 2 No certificate or Attending Physiclan; 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ို 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No · death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tij of certifier JUX 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANNEL ST. BALTIMORE, MD 2/225.

State Registrar AZEEM

3

Nomen 31. Date filed (Month, Day, Year)

AUG 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** August 5, 10:33 AM Richard L. Sullivan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 1939 Washington, D.C 68 Director 578-50-6279 Sept. 14, Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 No Director Maryland | Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with Funeral 20817 United States 5500 Friendship Blvd., #826N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. If the statements once. Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2KINo Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Financial Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis M. Sullivan Katherine Schrider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Marwood Ct., Rockville, Maryland 20850 Kevin M. Sullivan / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Aug. 10, 2008 | Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License-Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failur. List only one cause on each line. Immediate Cause (disease or condition resulting in death) astenosclesotic collo vasculos **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ward (_____ | Records, | Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown res cholestero Jenna 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□Yes 2☐No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 55410. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) / expense GThe Chefu 8600 Old George frown Rd Be Mesda, uno 20032. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** Studzinski 10 1:09 dward homas 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Baltimore Mercy 6. Sex 1221 M 2 ☐ F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 21,1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 219-22-0376 80 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 7801 W. Collingham Drive Apt. D Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Plumber Mechanic 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Studzinski Eva Pietrowicz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is I any Injury or other trausonce. 7801 W. Collingham Drive Apt. D Dundalk, MD 21222 Mrs. Joan M. Studzinski (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/13/2008 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Non-Small Cell Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical ası IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

by the a

has

hours after the Hospital

within 24

28a-f show

or items 23a

"natural"

death with ö

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

(Check only one)

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier mo

29c. License number 29d. Date signed (Month, Day, Year) NPI#1881854925

10,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore. Paul St. St. lodi D. Krumrine MY 301 32. Registrar's Signature 31. Date filed (Month, Day, AUG 13

State Registrar

Medical

			1 - State Registrar		C	ertif	icate of	Death		Re	g. No. 2	nα	26037
	Physici: /Medic		1. Decedent's Name (First, Middle, Last) RONALA AV	thur Sv	nith)			2	Date of Death Month	10 20	00	3. Fimbot beath 5',50 P M
Ì	Examin	_	4a. Facility Name (If not institution, give stre Battimove Rehabilitati	et and number) By Extended	Care	41:	Loch		of Death		4c. County o		ore Co.
	Funeral Director		5. Social Security Number 6. Sex 213-34-6655	7. Age (In yrs. 72	last birthd Yrs	M	Under 1 Year onths Days		24 Hrs. 8 Min.	Date of Birth (Month, Day, June 29		9. Birtho	place (State or Foreign ntry) land
4.0	show dat	'n	Usual Residence of Decedent 10a. State 10b. Counfy		ty, Town o	r Locati	on						10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	with the M s or 28a-f be notifie	Directo	Maryland Balt 10e. Street and Number 8230 Dundalk Avenu	imore			10f. Zip Code	2122		dalk	g. Citizen of W		ntry?
co O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No		If Ye	Decedent of Hes, specify Cub	lispanic Ori an, Mexicar	gin? (Specif	fy Yes or No- can, etc.)	14. Race Black		can Indian,
Maryland 21215-0036	72 hours a natural", o ilical Exan	eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat (Specify only highest grade co	Year or Dates: VIEL.	16a. De	ecedent	Yes 2 2 No 's Usual Occup d of work done NOT use retired	Specify: eation during mos	t of working	, 1	Specify: 6b. Kind of Bus		nite dustry
2121	led within lygiene. ner than "	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)			NOT use retired	ger		First, Middle, M	Marine		lustry
yland	ould be fil Mental H Iarked ott	To Be	17. Father's Name (First, Middle, Last) Sydney Smith		1]	Rose S	Smith			
	is 1 and 2 sh of Health and ftem 27 is m other traum			Son)	8:	202	Dundal on (Name of			Route Number,		d 21	.222
Baltimore,	Eant: If Ite		20a. Method of Disposition 12 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	noval from State	cemetery,	<i>cr</i> emate wn (cemeter	у Е	8/14/2	2008	Baltim	ore,	Maryland
Bal	Depar Impor any In		21. Signatury of Juneral Service Licensee	Pal	-	79	922 Wis	e Ave	. Dur	ome of i	Marylan		21222
y.	Physician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the deacause on each line.	evelo	va.	Her	novi	hag	e	st,		Approximate Interval Between Onset and Death
	/Medical Examiner	J.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consect Metast Due to (or as a consect	at 1		Lung	Ca	rcin	oma			
	xecuted and al-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	Due to (or as a consec									
68760,	icate be e physician s the buris	Medical E	C _d										
.O. Box	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death		topic pregnanc ther (specify) _	у			23d. Date Mor		ery Day Year
rds, P.	w requires that been signed to should be det	þ	Part II. Other significant conditions contri	buting to death but not res	sulting in th	ne unde	rlying cause giv	en in Part I				ibute to t 3 ☐ Pro	the cause of death? bably 4 Unknown
Division or Vital Records,	The law ate has b page 2 sl	Completed								24a. Was ar autops perform 1 Yes 2	y ned? d	Vere autorior to co eath? □ Yes	opsy findings available ompletion of cause of
Vit	Physiclan: The this certificate ral director, pag	Be o	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2] ER/Outpa	ationt	3∏ DOA Oth	ier.		Check only one		(0	
ion or	Attending Physic death. ector: After this by the funeral di	ition: To	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ne of	28c. Inju Wo		28	e 5 ☐ Reside d. Describe ho			ny)
Divis	= E = E	Certification:	· · · C Could not be	28e. Place of injury - At h building, etc. (Spec		, street	, factory, office		28	lf. Location (Sti City or Town		er or Rui	al Route Number,
	the Hospital hin 24 hours a the Funeral I npietely filled	Medical (lan: To the best of my kn r: On the basis of examin and manner stated.						d at the time, da	ate and place, a	and due	to the cause(s)
	To with	Z	29b. Signature and title of certifier Leour	Wills I	II /	1D.	29c. Licens	136	5	29	od. Date signed	(Month	, 2008
8	11		George E. WI	pleted cause of death (Ite	m 23a) (Ty	rpe, Prii	O Lock	Rai	sen B	outeva	d, Ba	ttin	2008 nove MD. 21/218
	Sta Registi	rar	31. Date filed (Möhth, Day, Year) AUG 1 3 2008	32 Registrar's Sign	ature	£345	Se B					_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM DENNIS THURLOW AUGUST 10,2008 1:30 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6907 EASTBROOK AVENUE BALTIMORE N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F 217-02-6515 39 **Director** JULY 4,1969 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Funeral Director MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6907 EASTBROOK AVENUE 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. Specify: Completed by 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) MAINTENANCE STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN E. THURLOW 2 BETTY BARVIR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY THURLOW/ MOTHER 6907 EASTBROOK AVENUE, BALTO., MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 8/14/08 4 Donation 5 Other (Specify) PARKVILLE, MARYLAND 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licensee 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRR HOSIS Physician /Medical Due to (or as a consequence of): AND Accord L 71 20 48 Examiner HERATITIS Sequentially list conditions, Examine it any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Kd Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

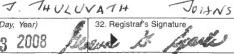
within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1)45040

29d. Date signed (Month, Day, Year)

HOPKINS HOSPITOL BALTIMORE MALLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G890, 4/21/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 26039 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Y 7:29 AM AT AYLOR AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year), ⁵ 246 <u>~62</u>42595 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 53 Director Nember! LILINOIS Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No NA BAHLMOSE Directo and 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2,2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 Tho African American Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kin of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) URSE TRIVE Dite 17. Father's, Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be eleste ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street DAHIMORE MARGARI 21205 Lumpkins 520 esta. 20b. Place of Disposition (Name of cemetery, crematory or other place)

METRE N. Cematery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important; If Ite
any injury or otl 1 Burial 2 Cremation 3 Removal from State August 16, 2008 BAHIMERE, MARY AND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nancy m. wallace 21. Signature of Funeral Service Licensee SERVICO EUNERAL selace 3405 W. FRANKLIN Steet BAITIMOVE, MARYLAND 21229 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he fit failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MAGGNANT BRAIN Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)

Physician /Medical Examiner bunal-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

"natural",

Baltimore, Maryland 21215-0036

Exami	Cause (Disease or injury that initiated events	С.					
	resulting in death) Last	Due to (or as a consequence of):					
Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 ☐ Ectopic preg 5 ☐ Other (speci			23d. Date of delivery Month Day	Year
þ	Part II. Other significant conditions o	ontributing to death but not resulting in th	ne underlying cau	use given in Part I.	23e. Did tobacc	o use contribute to the cause	of death? ☐ Unknow
Completed					24a. Was an autopsy performed?		igs availab of cause o
0	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
P B	examiner? 1 ☐ Yes 2 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpat	tient 3 DOA	Other: 4 \(\sum \) Nursing H	lome 5 ☐ Residence	6 ☐ Other (Specify)	
	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time	e of 28c.	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, of	ffice	28f. Location (Street City or Town, Sta	and Number or Rural Route Nate)	lumber,
edical C		ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.					ise(s)
Z	29b. Signature and title of certifier	·	29c. L	icense number .	29d. [Date signed (Month, Day, Year))
	THE T	2 N	1.D.	ZES-0	00 Aug	JUST 12,20	800
	30. Name and address of person who	completed cause of death (Item 23a) (Tvi	oe. Print)				

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar

PABLO

31. Date filed (Month, Day, Year)

RECINOS

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^{Day} 2008 **Physician** August 5:30 А м Rosa C. Tunon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 19924 Silverfield Drive Gaithersburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 95 Director 262-78-8645 September 4, 1912 Cuba Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinat must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 19924 Silverfield Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 🕅 If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Cuban 1X Yes 2 □ No Specify: Hispanic 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Business Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andres Calderin Leonor Lasaga ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19924 Siverfield Drive, Gaithersburg, Maryland 20886 Maria T. Carbonell /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 15, 2008 South Miami, Florida Woodlawn Park 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville Inc. 300 West Montgomery Avenue, Rockville, Maryland M01360 20850-2805 21. Signature of Funeral Service Licensee who offen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Weeks Heart Failure /Medical Due to (or as a consequence of) Examiner 01d Coronary Artery Disease Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Atherosclerosis and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si Frailty - Advanced Age Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis autopsy performed? certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 D31319 August 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto S. Albiol, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 4:40P_M **Physician** Donald Gerald Vaughn 8, Aug. /Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
_____ 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 3M 2 □ F 216-14-7391 86 Maryland Director 1922 18, Usual Residence of Decedent 10c. City, Town or Location Pikesville 10b. County 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, The Middial Evant har must be mailled at 10a State Baltimore Maryland Director 1 ☐Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 7 Jameson Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ⊠Yes 2 No If Yes, Give WW 2 Year or Date WW 2 Specify: Black 1 Never Married 2 Married 1 ☐Yes 2 No Specify ੬ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Yard Construction Foreman permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other traumatic event. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Campbell John Vaughn ပ္ 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Gode 21208 7 Jameson Lane Pikesville, Maryland 19a. Informant's Name/Relationship (Type. Print) Doretta Cooper/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet. 20c. Location - City or Town, State Owings Mills, 20a. Method of Disposition Cem. X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/15 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Fundral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 arris Part 1. 5 ter the discrete of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yens Immodate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) attending physician Physician/Medical the asn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy fort in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 →No 2 500 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 120 mys 29b. Signature and title of certifier than foon, MI) ALLENST 11, 2008 157088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Sellin, mi) 2/ Jes 301 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 13

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Registrar

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Baltimore, Maryland 21215-0036

certificate be executed

Box 68760,

P.O.

Division of Vital Records,

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death with

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Warbur ton **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 68 225-50-7115 March 6, IRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No BAHIMORE **Funeral Director** 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Numbe U.S.A. 21205 5021 tuenuc Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: If item 27 is marked other than ' SANDER 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be KuH WARBURTON John 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trainonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State BeLAIR, MAY/AND GATGRUS Aug 16, 2008 4 Donation, 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Conkline Part 1. Enter the disear e, or complications that caused to shock, or heart failur. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed bunial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 - Ectopic pregnancy Year Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DUIMONEU 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Fallure 20 No congestive Heart 25 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ٥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. To the Hospital

> 30. Name an ad ress of person who completed cause of death (Item 23a) (Type, Print) aVIa

(check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 12, 2008

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

AUG 2008 32. Registrar's Signature

ORIGINAL

			For State Registrar	State of Ma		epartment of Certificate			ептат пу	Reg. No.	800	260	43
	Physici	an	1. Decedent's Name (First, Middle, L.						2. Date of De Month	Day	7 0 ^{Year}	3. Time of D	
	/Medic		Claudine Wall			4h Chi Tai		cation of Death			County of Dea	6:45	īa"_
	Examin	er	4a. Facility Name (If not institution, git 6401 Loch Ray			Balt				40.	ocurry or boo		
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birt	hday) If Under 1		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av Year)	9. Bi	rthplace (State or I	Foreign
	Director		217-16-3032	1 □ M 2 🔀 F	87	Yrs. Months D	Days I	Tours Iviiri.	4/26			ltimore	,MD
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	n or Location						10d. Inside City	Li <i>m</i> its
	Maryla	or	MD		Balt	imore						1 XYes 2	No
	r 28a-	Director	10e. Street and Number		DQ.1 0	10f. Zip Co	ode			10g. Citiz	zen of What C	ountry?	
	th witt	al D	6401 Loch Ray	en Blvd	#543	212	239			US			
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent If Yes, specify	nt of Hispa Cuban, I	anic Origin? (Spe Mexican, Puerto	cify Yes or No Rican, etc.)	o- 1	14. Race - Am Black, Wh		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or Items 23a or 28a-1 ahow marked other than "natural; or Items 23a or 28a-1 ahow matte event, the Medical Exemite that the notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No	1□Yes 2√	No S	Specify:			Specify: B	lack	
Maryland 21215-0036	2 hou		15. Decedent's 8	ducation	16a.	Decedent's Usual C (Give kind of work of life. DO NOT use	Occupation	on ing most of worki	na	16b. Kii	nd of Business	s/Industry	
215	thin 7 e. an "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)				ng.		37 1	Deale 1 d as	Cab
7	ygien ygien ner th		12	41	P	araprofe		ona J. B. Mother's Name	(First Middle	1		Public	Sen
and	b d la b	Be	17. Father's Name (First, Middle, Last Claude P. Wall					Madie (, maidon	Ob, manifo,		
Š	should ind Men s marke umatic	L 2	19a, Informant's Name/Relationship		19b	. Mailing Address (S				er, City o	r Town, State,	Zip Code)	
	and 2 lith a 27 is r tra		Clarissa Beck	les/Daugh	ter 1	718 N. E	Bent	alou A	ve. Ba	alti	more,	MD 212	16
J.e	ss 1 a of Hea item rothe		20a. Method of Disposition 1 □ Burial 2 X Cremation 3		20b. Place of	Disposition (Name ry, crematory or other	of er place)		Date	20c. Lo	cation - City o	r Town, State	
Ĕ	Pages ment of I ant; If it ury or o		'4 Donation 5 Other (Spec				ık.		Unk.	Balt	imore,	MD	
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or othe once.		27. Signature of Funeral Service Lic	onsee	214	22. Name and		4300 W	abash	Аче	nue		
	00300		232 Part Enter the disease or co	polications that cause	d the death Dou	March E	PH of dving s	Baltimo	ore, I	AID	21215	Approximate	
H,			23a. Pa.d. Enter the disease, or co spock, or heart failure. List on Impediate Cause (Final	^			,,					Onset and De	eath _
	Prysician /Medical		ease or condition resulting in death)	- u	a consequence							2 mo	LTLS
	Examiner		O Sala II. Patras Bilana	h		- ,							
0_	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events	Due to (or as	a consequence	of):							
	ecute and trans	Examiner	that initiated events resulting in death) Last	c	a consequence	of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit	al E		320 10 (0) 40		5.,,,							
687	ficate p phys	edical		0	_					- 1			
Вох	h certi anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 ☐Ectopic preg	nancy			(1)	23d. Date of d		
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2.2No	4 Pregnant a		5 Other (spec					Month	Day Ye	ear
<u>О</u>	The law requires that the death cerate has been signed by the attending age 2 should be detached for use	Phy	9 Unknown Part II. Other significant conditions		out not resulting i	n the underlying cau	nevin ezi	in Part I	23e. Did	tobacco u	ise contribute	to the cause of de	ath?
	w requires that s been signed t should be det	d by	Part II. Other signmeant conditions	contributing to dealing	out not resulting i	ir tilo di lostiyalg odd	iso givan	ner die i	1	Yes 2	× No 3□!	Probably 4 □Ur	nknown
202	w requ	Completed							24a. Wa	s an	24b. Were	autopsy findings a	vailable
Re	he lav e has age 2	duic							aute per 1 ☐ Yes	opsy formed? 2 No	prior to death?	o completion of ca ? es 2□ No	use of
Vital Records,		a)	25. Was case referred to medical				2	26. Place of Deat					
	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□ER/O	stpatient 3 DOA	Other:	4 Nursing Ho				pecify)	
o L	Attending Physician: or death. ector: After this certification in the funeral director.	on:	27. Manner of Death	28a. Date of Inj (Month, Da		njury	c. Injury a Work?	•	28d. Describe	how inju	y occurred		
Sio	tendideath.	icatl	2 Accident investigat 3 Suicide 6 Could not	ho	iling - At home for	M arm, street, factory, o		s 2□No	28f. Location	(Street ar	ad Number or	Rural Route Numb	99 <i>r</i> .
Division of	after a Direc	Certification:	4 ☐ Homicide determine	d 209. Flace of the	ic. (Specify)	ann, street, lactory, t	OIIICO			own, State			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Ex	Physician: To the best	t of my knowledge	e, death occurred at	the time,	, date and place,	and due to th	e cause(s	and manner	as stated. ue to the cause(s)	
	To the H within 24 To the Fi complete	ledical	one)	and manner s	tated.	70-	1:			20d Do		onth, Day, Year)	
	Son Toon	Σ	29b. Signature and title of certifier	1/	45	296.	License r	1Umber マ フ 4く	~	290. Da		8, 2008	~
1	(F) T	1	1 kmot	completed cause of	dage (Itam 1951)	(Type Print)	,00	2//2	•	Ju	Sur-	0) 2000	
(0/		30. Name and address of person wh	MD Dem	FM 29.	(Type, Print) S. Paca St. 1	Baltu	in MiD	21201				
	St	ate	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature								
	Regist	rar	AUG 13	2008	w K	Coule					-		
DI	BALL 47 D - 46	004		-									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2008

26014

	1	State Registrar				rtificate of		h	Date of De	Reg. No.	000	3. Time of Death
Physician		 Decedent's Name (First, Middle, L Mary Zuroms 							Month UQUS	Day	Year 2008	12:15a
/Medical Examiner		4a. Facility Name (If not institution, g				4b. City, Town,	or Location		uyus		County of Death	
	4	Future Care	Canton 1	Harb	or	Baltim						
Funeral Director		215-05-5476	Sex 7. Ag 1 ☐ M 2 🖾 F	9 2	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. 8. 6 Min. 9	Date of Bir (Month, Da -2-1	1b, Year) 9 1 5	9. Birth Cou Mar	place (State or Forei intry) yland
A ==	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limit
tor tor		MD		Ba	ltimo	ore						1 XYes 2 □ N
or 28a-f show the notified at Director		10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	intry?
rail		1300 S. Ellwoo				2122				USA		
any older traumatic event, the Medical Examiner must be notified at page. To Be Completed by Funeral Director	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No			Yes or No an, etc.)	l l	4. Race - Ameri Black, White, Specify: Whi	, etc.
r, the Medical I		15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during me	ost of working		16b. Kind	d of Business/Ir	ndustry
idm	-	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire Homemak				Т	n own	homo
္မ		8th 17. Father's Name (First, Middle, La	st)			TOMOMO		ther's Name (Fi	irst. Middle	1		nome
atic even To Be	1	Fadey Klemato					Anı	na Zal	tko			
		19a. Informant's Name/Relationship		L	19b. Maili	ng Address (Street	and Num	nber or Rural Re	oute Numb	er, City or	Town, State, Zi	p Code)
ner tra		Richard Leon	Zuromski		430	5 Winte	rode			imore	, MD 2	1236
ury or ou		20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec			ıklawı		1		2008	Balt	ation City or T	, MD
any n		21. Signature of Funeral Service Lice Marea H	ansae Zanni	ne	2 20	2. Name and Addre	oss of Fac	ing St	eph N	N. Za iltim	nnino Tore, M	Jr.FH D 21224
		23a. Part1. E ar II e disease, or co shock, or heart failure. List on	lications that caused by one cause on each li	the death	n. Do not en	ter the mode of dyi	ng, such a	as cardiac or re	spiratory a	rrest,		Approximate Interval Between
an	1	Immediate Cause (Final disease or condition	a Breas	+ cu	ncer							Onset and Death
cal ner	ı	resulting in death)	Due to (or as	a consequ	uence of):							
		Sequentially list conditions,	b. Due to (or as	a consequ	uence of):							
Examiner	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			,							
		resulting in death) Last	c	a consequ	uence of):							·
	1	IF FEMALE:									-	
y Physician/N		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yho 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3[□Ectopic pregnanc □ Other (specify) _	у			23	3d. Date of deliv Month	rery Day Year
P A	'	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	inderlying cause gr	ven in Par	rt I.		tobacco us		the cause of death?
should	1											
CI Q									24a. Was auto perfe	psy ormed?	prior to co death?	opsy findings availab ompletion of cause of
e C		25. Was case referred to medical					26 Pla	ice of Death (C	1 Yes	2 No	1 🗆 Yes	2 No
director, page To Be Com		examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 1	ER/Outpatier	nt 3□ DOA Ott	ner	Nursing Home			□Other (Speci	ify)
<u>a</u> _	-	27. Mannum Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o	of 28c. Inju	THE RESERVE OF THE PERSON NAMED IN			how injury		
catic		2 Accident investigat	ion			M 1	Yes 2[
<u>≥</u>		3 ☐ Suicide 6 ☐ Could not determine		ury - At ho c. (Specify	me, farm, sti	reet, factory, office		28f.	Location (City or To		Number or Rur	ral Route Number,
completely filled in Medical Cert		29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medicel Ex-	Physician: To the best eminer: On the basis o and manner st	f examinat	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date a	and place, and eath occurred a	due to the at the time,	cause(s) a date and p	ind manner as solace, and due t	stated. to the cause(s)
completely filled in by the		29b. Signature and title of certifier NEW MAP WHILE MAP	D			29c. Licens		1465			signed (Month, 8/13/0	
7		30. Name and address of person wh	o completed cause of o	leath (Item	23a) (Type,	Print) 1 K-200; K	eiste	rstown	, M	0.2	1136.	
State		31. Date filed (Month, Day, Year)	008 Registr	ar's Signat	ture							
Registrar		AUG 1 3 2	UUB JAR	s 13	Sol	refer						
Rev 1/2001								14/15				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10:00 **Physician** 2008 Carl Francis Abell, Sr. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 23289 Colton's Point Road St. Mary's Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthdav) 6 Sex **Funeral** Year) Months Days Hours Min. 1⊠M 2□ F 70 Yrs. 213-38-1944 September 8,1937 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examiner must be notified at 1 ☐Yes 21 No Director St. Mary's Maryland Avenue 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23289 Colton's Point Road 20609 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi th and Mental P 7 is marked otl Be Dorothy Victoria Bailey John Fulton Abell, Jr. ల 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trau Avenue, MD 20609 23289 Colton's Point Road Barbara Anne Abell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 11, Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Cemetery 2008 22. Name and Address of Facility 21. Signature of Funeral Service Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 200 23a. Part I. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician certificate be Physician/Medical as the IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1∐Yes 2,⊠No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of Injury at Work? 28d. Describe how injury occurred al or Attending F after death. I Director: After After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, M.D. Leonardtown, MD 20650 40900 Me/mchants Lane Ste. 205 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 1 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06019 State of Maryland / Department of Health and Mental Hygiene Derek Ray Bittinger 2008 26046 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day August 6, 2008 Physician/ 1758 hrs ' Examiner Me Derek Ray Bittinger 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Garrett Youghiogheny River 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Foreign Pennsylvania If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours April 3, 1972 Country) Director 36 220-94-8284 1**X** M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 X No s 23a or 28a-f show e notified at once. 28a-f shov Friendsville MD Garrett with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21531 773 Garletts Rd. 14. Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No Yes 2 No specify. White If Yes, Give Year 4 X Divorced hours after þ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "
or other traumatic event, the Medical I. Masonry Stone Mason 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenna Compton Larry Bittinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B 773 Garletts Rd., Friendsville, MD Larry Bittinger/Father 20c. Location - City or Town, State Baltimore, N permit. Pages I and Department of Healtl Important: If item injury or other trau 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Bittinger Family Cemetery Aug. 10, 2008 Friendsville, MD Other Specify: 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval hysician Between Onset and Death **J**ledical Drowning and head injuries Immediate Cause (Final disease ∟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and AMENDED 23a,27,28a-f, perME, g883 9/11/08 TT Physician/Medical X UNPENDED g physician a 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ģ σ. Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has page 2 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Other, examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ۵ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death subject assaulted Certification: Yes 2X No Natural Pending Fnd 8/6/08 Fnd 5:58 pm 24 hours after death. Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Youghiogheny River Friendsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 determined (Specify) river 4 X 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

2008

31. Date filed (Month, Day, Year,

32. Registrar's Signature

ORIGINAL

		For State	State o	f Maryland		rtment of H	lealth and N Death	Ĩ	_	000	0601
		Registrar 1. Decedent's Name (First, Middle, Las	st)		001	incate or i	Death	2. Date of De	Reg. No.	UUB	3. Time of Death
Physici		Beatrice Marie	_	0.01				Month 08	Day	Year	2:20 P M
/Medio		4a. Facility Name (If not institution, give		eck		4b. City, Town, or	r Location of Death	00	06 4c. C	2008 ounty of Death	1 2:20 P
Examin	iei	Oakland Nursing &		,	LLC	0ak1an	d			Garrett	
Funeral		5. Social Security Number 6. S		7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
Director		220-05-8756	□M 2 ⊠ F	90	O Yrs.	Months Days	Hours Min.	(Month, Da 09/30/		Mar	yland
p		Usual Residence of Decedent		1							
ırylar show	_	10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	cto	WV Grant			Baya						
or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
ath w	la	P.O. Box 195		1	140.1	26707		1 V N	1	USA 1. Race - Americ	oon Indian
er de items	Funeral	11. Marital Status	12. Was Dec Armed Fo 1 ☐ Yes		i. 13. V	vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.))- 14	Black, White,	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ive	1	☐ Yes 2K No	Specify:		5	Specify: Wh	ite
tura atura	p	15. Decedent's Ed	lucation			lent's Usual Occup			16b. Kind	d of Business/In	
nin 72 n "ne Medie	plet	(Specify only highest gra	de completed) College ((Give life. [kind of work done o OO NOT use retired	during most of worl d)	king			
yiene giene rr tha	Completed	12th	Odliege (1 401 04)	Но	memaker			Se	1f	
be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden S	urname)	
uld by Menta rked tic e	ToE	Sterling Ellwood	Criswe	211			Mary	Rudo1	.ph		
and hand series		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zij	o Code)
and 2 salth n 27 l		Patricia A. Stone	r				, Bayard,	WV 267	707		
of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domoval from	20b. Pla	ace of Dispormetery, crem	sition (Name of natory or other plac	ce)	Date	20c. Loc	ation - City or T	own, State
Pag nent ant: I		4 □ Donation 5 □ Other (Specif		1 .	ga Cre	matory	08/08	3/2008	Morga	ntown,	WV
rmit. partr ports y inji		21. Signature of Funeral Service Licer	isee // //		22	. Name and Addre	ss of Facility F1	redlock	Funer	ral Home	2
9 9 5 6 9		Wm HANA	wish.	\(\sigma \)	P.	0. Box 4	, Piedmor	nt, WV 2	26750		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the death.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1		an co						Onset and Death
/Medical		resulting in death)	Due to	(or as a conseque							- Janes
Examiner		Sequentially list conditions,	b								
p #	jue	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseque	ence of):						
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a conseque	oneo of):						
cate be executed oblysician and the burial-transit			Due to	(or as a conseque	ence or,						
icate be executed physician and the burial-transit	dical		_d								
The law requires that the death certific tte has been signed by the attending to page 2 should be detached for use as	by Physician/Me	IF FEMALE:	23c. If ves. ou	itcome pf pregnan	ncv				25	Od. Data of dalis	(OD)
atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live	birth 2□Fetal nant at time of de	death 3□	Ectopic pregnancy Other (specify)	у		20	3d. Date of deliv Month	Day Year
the d	ysic	1 Yes 2 No 9 Unknown	9□Unkr		u 0_	g outlot (appeality)					
that ed by deta	유	Part II. Other significant conditions of	ontributing to d	leath but not resul	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
uires tha signed l	db							1 🗆	Yes 2□	No 3 Pro	bably 4 Unknov
w requir	ete							24a. Was	an I	24h Wara aut	opsy findings availab
ne lav has ge 2	Completed		-					auto		prior to co	ompletion of cause of
	ပိ	OF Was some referred to modical						1□ Yes	2 No	1 ☐ Yes	2 □ No
Physician; The this certificate har al director, page	Be	25. Was case referred to medical examiner?	Hospital:	U		t all DOA Oth	26. Place of Dea				
a ⇒ B	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date		R/Outpatien 28b. Time of	1 3 DOA	42 Nursing H	ome 5 ☐ Res 28d. Describe			ify)
ding After fune	ö	Natural 5 ☐ Pending	(Mor	nth, Day Year)	Injury	Wor	rk? Yes 2 ∐ No	200. 200020	non mjany	33341134	
Attending r death. ector; After by the funer	ical	3 Suicide 6 Could not b		e of injury - At hor	ne, farm, str			28f. Location /	Street and	Number or Rui	al Route Number,
after Dire	Certification:	4 ☐ Homicide determined		ling, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State)		
splta ours neral filled		29a. Certifier Certifying Pr	ysician: To th	e best of mv know	vledge, death	n occurred at the ti	me, date and place	, and due to the	cause(s)	and manner as	stated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		niner: On the l				opinion, death occu				
o the o the o mpl	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
⊢≯⊢ŏ		P an		00- 1	2	77.0 €	15/		08/0	7/2008	
		30. Name and address of person who	completed cou	se of death (Itam	23a) /Time	H26	154		-0,0		
	6						Oakland	Marul	and 2	1550	
C	ate.	Dr. P. Daniel Mil 31. Date filed (Month, Day, Year)		Registrar's Signati		, DEON 65.	Vaktand	ratyl	u Z	1000	
Sta Regist			2008	Carthophia A	de de	nooth)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Sondra Jean BUTLER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Nov. 20,1953 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 ☐ M 2 🔀 F 54 Yrs. Months Pennsylvania 219-60-4933 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Modical Examinar must be notified at Maryland Washington Hagerstown 1XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and 2 should be filed within 72 hours after death with lealth and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 21740 U.S.A. 181 South Prospect Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔼 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) newspaper sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Lane Harry Gilmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) 181 South Prospect Street, Hagerstown, Maryland 21740 Larry E. Butler, Sr. - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 31, 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2008 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home habit Gs 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respire /Medical Due to (or as a consequence of): Examiner Cardiopela Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Ant ango a burial-tran and Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medlcal 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown The law requires that 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, regente 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? typentip leni 24a. Was an Motan cate has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☑No 1 Departient 2 ER/Outpatient 3 DOA e Hospital or Attending Phy 24 hours after death.
Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Division (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 C-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 26 2008 D183(G talt mo

State Registrar 31. Date filed (Month, Day, Year)

VASAWT DATTA

32. Registrar's Signature

JUL 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3 MS MILLST

MACERS-TOWN MOZIONO

O-HO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Ameno#27.PerPhys.PGC7-31-08cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 **Physician** July 09 4:20 pM Claudette Ann Bailey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St.Mary's Leonardtown 8. Date of Birth (Month, Day, 08/25/ If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🕇 F District 57 579-66-5906 Director Columbia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Y Yes 2 No Director MD St. Mary's Lexington Park 2 should be filed within 72 hours after death with the is and Mental Hyglene. is marked other than "natural", or items 23a or 28a-raumatic event, the Medical Examiner must be notified. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 46361 Columbus Dr. # 106 20653 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) DC Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Bailey Claudine Smith traumatic ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. 21310 Castaway Circle #106 Lexington Mack Easy Holland Son 20a. Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Washington National Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility • Wesley Chavis III FUneral ServiceINC 21. Signature of Funeral Service Licensee 0684 Southern MD BLVD Dunkirk, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 40 cardy Physician disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions Examiner i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acidosi's Due to (or as a consequence of) burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy page 2 1 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

law requires that the death certificate be executed and Box 68760. attending physician for use as the buria P.O. ed by the signed by Records, has e 2 s The certificate or Vital After t Division death.

Baltimore, Maryland 21215-0036

or Attending Director: , fo the ... within 24 hour. ... the Funeral Dire

Medical State Registrar

(Check only one) Medica xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and of certifier

29d. Date signed (Month, Day, Year)

THREE NOTCH Rd

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year, JUL 3 1 2008

29a. Certifier

Physician

/Medical

Examiner

Funeral Director

29a. Certifier (Check only one)

Director

Funeral

Be Completed by

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			artment of Health and	All Copies A Mental Hvai	_	ic.
State Registrar			rtificate of Death		. No. 20	08 26050
1. Decedent's Name (First, Middle, Las	")			2. Date of Death Month	Day Y	3. Time of Death
	abeth	Bankins-I		August		2:15 p.m.
4a. Facility Name (If not institution, give	,		4b. City, Town, or Location of Dea	ath	4c. County of	
44931 Hickory Lan 5. Social Security Number 6. Se		e (In yrs. last birthday)	Hollywood If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	St. Ma	ry 's . Birthplace (State or Foreign
217-66-1613 Usual Residence of Decedent	⊐м 2К□ г	45 Yrs.	Months Days Hours Mir	(Month, Day,) 11/12/19		New Jersey
10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryland St. M	ary's		Hollywood			1 □ Yes 2X2XNo
10e. Street and Number			10f. Zip Code	109	j. Citizen of Wh	at Country?
44931 Hickory Lan	ding Way		20636		Jnited :	States
11. Marital Status 1 ☐ Never Married 2 🔯 Married	12. Was Decedent Armed Forces? 1 XYes 2 ☐ I If Yes, Give	No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:		Black,	American Indian, White, etc. Black
3 Widowed 4 Divorced	Year or Dates:					
15. Decedent's Ede (Specify only highest grade Elementary/Secondary (0-12)	ication le completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)		b. Kind of Busi	ness/Industry
	8	Profes	ssor		Educat	ion
17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle, Ma	iden Surname)	
James Eugene Bank				ra Ernesti		
19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Mailii	ng Address (Street and Number or F	Rural Route Number, (City or Town, St	ate, Zip Code)
<u>Michael Lee Bush</u>	/ Husband	7	Hickory Landing			
20a. Method of Disposition						
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, cier	psition (Name of matory or other place) Heart of Mary 08,	/13/2008 L	exingto	
		Immacule I	Heart of Mary 08, Name and Address of Facility B1	/13/2008 Locinsfield	exingto Funeral	n Park, MD Home, P.A.
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4 □ Donation 5 □ Other (Specify. 21. Signature of Funeral Service Licens	Due to (or as b. Due to (or as b. Due to (or as d. Due to	cemetery, createry, create	Heart of Mary 08, 2. Name and Address of Facility B1 2955 Hollywood Roter the mode of dying, such as cardi	23e. Did toba 1	23d. Date Monti	MD Park, MD Home, P.A. MD 20650-0279 Approximate Interval Between Onset and Death of delivery Day Year ute to the cause of death? Probably 4 2 Unknown ere autopsy findings available or to completion of cause of ath?
21. Signature of Funeral Service Licens Kyle S. Simons 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of lineadisease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions can be separated by the service of the separated by the service of the separated by the service of the service o	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due to	cemetery, createry, create	Heart of Mary 08/2. Name and Address of Facility B1 2 955 Hollywood Roter the mode of dying, such as cardi. Ectopic pregnancy Other (specify) 126. Place of December 126.	23e. Did toba 1	23d. Date Month ccco use contrib 2 \(\text{No} \) 3 24b. We private decide the privat	MD 20650-0279 Approximate Interval Between Onset and Death of delivery Day Year ute to the cause of death? Probably 4 Vinknown ere autopsy findings available or to completion of cause of ath? Yes 2 \(\) No
21. Signature of Funeral Service Licens Kyle S. Simons 23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due to	cemetery, cier Immacule I 22 20 22 32 32 34 35 35 36 36 37 37 38 38 38 38 38 38 38 38	Heart of Mary 08/2. Name and Address of Facility B1/2. So that the mode of dying, such as cardi. Ectopic pregnancy Other (specify) Inderlying cause given in Part I.	23e. Did toba 23e. Did toba 1	23d. Date Month	n Park, MD Home, P.A. MD 20650-0279 Approximate Interval Between Onset and Death of delivery n Day Year ute to the cause of death? Probably 4 Wunknown ere autopsy findings available or to completion of cause of ath? Yes 2 \(\) No (Specify)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical Medical Certification: To

Physician /Medical **Examiner**

and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40055751 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address o 40900 Merchants Lane, Leonardtown, Maryland 20650 Jennifer Schmidt, D.O., Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar **AUG 0 8**

Division or Vital Records, P.O. Box 68760,

Physician /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to It lems 23 aor 28a-f show ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 þ Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Be ပ္ **Physician** /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Physician/Medical þ Completed Be Certification: To this 27. Manner of Death 1. Natural After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign D64615 July 27, 2008 Mame and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855 32. gistrar's Signature \$1. Date filed (Month, Day, Year) State

Registrar

JUL 3 0 2008

			1 - State Registrar	-	epartment of He Certificate of D	eaith and Mental Hy leath	/giene Reg. No		26052
	Physici		Decedent's Name (First, Middle, Last) LAWRENCE		BROWN	Date of D Month	Day	·	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street an		4b. City, Town, or L	ocation of Death	21 .	2008 County of Death	9:35 A ^M
7			4330 Torque Street			Heights	Pr	ince Ge	orge's
24	Funeral Director		5. Social Security Number 216–34–1003 6. Sex 12 M 2	7. Age (In yrs. last birthe	Monthe Dave		ay, Year)	9. Birthpla Count Mar	ace (State or Foreign ry) Yland
	and w t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10	Dd. Inside City Limits
	Maryl -f sho ied a	ğ	MarylandPrince Geor	ge's Capit	tal Height	S			1 □Yes 2√□ No
	h the or 28a or noti	Director	10e. Street and Number		10f. Zip Code		10g. Citi	izen of What Count	ry?
	23a c ust be	la	4330 Torque Street		2074	3		USA	
	tems	Funeral	Arm	Decedent Ever in U.S. ed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.)	0-	14. Race - America Black, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	X X Year	Yes 2 □ No VIETNAM s, Give or Dates: —ERA		Specify:		Specify: Bla	
15	n 72 ł "nat	Completed	15. Decedent's Education (Specify only highest grade comple	eted) ((Decedent's Usual Occupat Give kind of work done du life. DO NOT use retired)	ion ring most of working	16b. Ki	ind of Business/Ind	ustry
72	withii iene. r than	ошь	Elementary/Secondary (0-12) Colle 12th 2v	ege (1-40r 5+)	Contractor		801	f Emplo	r.o.d
	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)			8. Mother's Name (First, Middle			yea
/lar	Menta	To E	Lawrence T. Brown	Sr		Marion E. T	urne	r	
Maryland	2 sho and Is ma	·	19a. Informant's Name/Relationship (Type. Prins) 19b. N	Mailing Address (Street and	d Number or Rural Route Num	ber, City o	or Town, State, Zip	Code)
	s 1 and 2 of Health a item 27 Is		Russell A. Brown (Se		7 Vista V	iew Ct. Ral			
JO.	ages nt of H : If ite		1 ☐ Burial 2 12 Cremation 3 ☐ Removal	Irom State	Disposition (Name of crematory or other place)	1		ocation - City or Tov	
Baltimore,	aftme artme ortani Injury		4 □Donation ¹ 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Metro	Crematory	7-28-08 okacikons Mort	Bal	timore,	Md.
ä	Depar Impo any I		Jarry J. Beese Mc	2483		St. Annapoli	_		1
	**		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final	RDIOPULMONARY	ARREST				Onset and Death
j	/Medical		resulting in death)	e to (or as a consequence of)					
и	Examiner	_	Sequentially list conditions, b.	PERTENSION					
	ted isit	Examiner	cause. Enter Underlying	e to (or as a consequence of) ABETES MELLIT					
	tificate be executed g physician and as the burial-transit	xan	that initiated events	e to (or as a consequence of)					
68760,	e be e	calE	C _d						
	E 00 m	ledical							
Вох	The law requires that the death cert ate has been signed by the attendin bage 2 should be detached for use a	Physician/M	ZSD. Was decedent pregnant	s, outcome pf pregnancy live birth 2 Fetal death	3 ☐Ectopic pregnancy			23d. Date of deliver	
O.	ie dea the at ned fo	sici	1 Ves 2 No. 4	Pregnant at time of death Jnknown	5 ☐ Other (specify)			Month I	Day Year
Δ.	ires that the de signed by the s	Phy	Part II. Other significant conditions contributing	to death but not resulting in the	he underlying cause given	in Part I. 23e. Did	tobacco ı	use contribute to the	e cause of death?
Vital Records,	uires f signe id be o	d by			ground and a second ground				ably 4X Unknown
S	w require been sign	Completed				24a. Wa	s an	24h Were auton	sy findings available
Be	he lav e has age 2 :	ошо				auto per	opsy formed?	prior to com death?	pletion of cause of
ta	an: T	Be C	25. Was case referred to medical			1 Yes 26. Place of Death <i>(Check only</i>		1 ☐ Yes	No No
	nysici nis cel direc	ToB	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpa	Othor		•	6 □Other (Specify))
n 0	Attending Physiclan: r death. ector: After this certific by the funeral director.			Date of Injury (Month, Day Year) 28b. Tim		at 28d. Describe	how injur	y occurred	
Sio	tendi eath. tor: A the fu	catic	2 Accident investigation		M 1 □ Y€	es 2 No			
Division or	al or Al after d I Direc d in by	Certification:	determined 200.	Place of injury - At home, farm puilding, etc. <i>(Specify)</i>	i, street, factory, office	28f. Location City or To	(Street an own, State	d Number or Rural)	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, on the basis of examination and/or manner stated.	death occurred at the time or investigation, in my opi	, date and place, and due to the nion, death occurred at the time	e cause(s) e, date and) and manner as sta d place, and due to	ated. the cause(s)
	Tot Tot com	Ž	29b. Signature and little of certifier	1150:011	29c. License		29d. Dat	te signed (Month, E	Day, Year)
) (Was /x)	· fatricea A	wright	20 MD# 13	0140	JULY	23, 2008	3
•	1/100		30. Name and address of person who completed PATRICIA ANN WRIGHT,	N D HANG FO	TRITING OFFI	EET NW, WASHING	STON,	DC 20422	/688
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 2008	2. Registrar's Signature	had a				
Di	ricgisti	004	/-	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:30 p^M Alfred Carver 2008 Bailev Ju1y /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 907 LaGrande Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F June 25, 1925 Kentucky Director 405-24-3816 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 No Director Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20903 907 La Grande Road by Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 11∑l'Yes 2 □ No If Yes, Give 143 - 146 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 💢 No Specify. 3X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Howard University Facility Manager Engineer es 1 and 2 should be filed wi of Health and Mental Hygler fitem 27 is marked other th r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Bailey, Sr. ပ္ Edna M. Burts 19a. Informant's Name/Relationship (Type. Print)
Melody Bragg (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
924 Schindler Road Silver Spring, Md. 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 anent of He Int. If item 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department o Important: If any Injury or Quantico Cemetery 07/31/2008 Triangle, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W.H. Bacon Funeral HOme, Inc. 21. Signature of Funeral Service Licensee Sacon (C36/3447 14th St. N.W. Washington DC 20010. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY SCHEMIC /Medical Due to (or as a consequence of): Examiner LSCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter detached for u 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYDERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending To the Hospital or Attending within 24 hours after dea h.
To the Funeral Director Afte completely filled in by the fun 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mucano MD D-0019400

State Registrar ERNESTO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

MID.

32 Registrar's Signature

344 UNIVERSITY BLUD W. SILVERSPRING, MYD

30. Name and address verson who completed cause of death (Item 23a) (Type, Print)

MF

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23,2008 **Physician** Frances Bolling 12:20pM Morgan July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery
9. Birthplace (State or Foreign Country) 11013 Lockwood Drive Silver Spring 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Year) Min. Months Days Hours 1 □ M 2 1 F Yrs Pennsylvania Director 335-14-6452 93 Aug. 22, 1914 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director VA Fairfax Alexandria 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3912 Woodley Drive 22309 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 🙀 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 4 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur E. Morgan Lucy Griscom 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 1 19a. Informant's Name/Relationship (Type. Print) Dan Bolling/Son 11013 Lockwood Drive Silver Spring,Md 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem 7/26/2008 Beltsville, Md 4 □ Donation 5 □ Other (Specify Funeral Service Licensee 21. Signature PHILIP Address & INALDI FUNERAL SERVICE, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. 9241 Columbia Blvd.Silve Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the Immediate Cause (Final **Physician** Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3
 Ectopic pregnancy for Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 2 🗆 No 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Spelifesidence 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To οĒ 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa July 25,2008 0101019492

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

8101 Hinson Farm Rd Alexandria, Va

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael David Lieberman MD

. Registrar's Signature

Year)

2008

P.O. Box 68760. Division of Vital Records. within 24 hours after death To the Funeral Director:

DHMH 17 Rev 1/2001

To the

completely

State Registrar

Medical

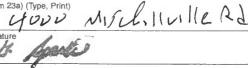
29a. Certifier

30. Name and aet

29b. Signature and title of cert

avakol; Registrar's Signature 31. Date filed (Month, Day, Year) 30 JUL 2008

ss of person who completed cause of death (Item 23a) (Type, Print)



1 🗹 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

raminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

08-05336		Please Type or Pri						ole.	
Ricky Lee Cripper			aryland /			and Mental H	lygiene	200	8 2605
	F	- For State		Certific	ate of Death		Reg.	NO.	
	V.	Decedent's Name (First, Middle,Last) Ricky Lee Crippen	- 11				2. Date of Death Month D July 11, 200	av Year	3. Time of Death 2154 hrs
4		4a. Facility Name (if not institution, give street a	and number)		4b. City, Tow	n, or Location of Deat		4c. County of Death	
•		735 Laurel Avenue			Ocean (City		Worcester	
Funeral	7	5. Social Security Number 6. Sex	7. Age	(In yrs. last bir	hday) If Under 1			MM/DD/YYYY) 9. Birti Foreigi	
Director		231-94-2283 1XM 2	F	38	Yrs. Months	Days Hours Mil	Sept 3,		ntry) VĀ
*	ŀ	Usual Residence of Decedent							
any		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
show	5	MD Worcester		Ocean	n City				1 Yes 2 No
Maryli 28a-f	Director	10e. Street and Number			10f. Zip Co	ode	10g	Citizen of What Coun	try?
death with the Maryland or items 23a or 28a-f show must be notifized at once.		104 4th St.			218	42		USA	
ms 2.	Funeral		as Decedent ned Forces?	Ever in U.S.		of Hispanic Origin? (\$ Cuban, Mexican, Puert		14. Race - Americ White, etc.	can Indian, Black,
r death	틾	Named 2 Married 1	Yes 2	X No			1.4	0 × D1-	al.
s after	2	3 Widowed 4 Divorced If Yes, G or Dates 15. Decedent's Education (Specify only higher	:	minted) 16a	1 Yes 2 X	No specify: cupation (Give kind of	work done	Specify: Bla	
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36 in 72 than diral	ble	12th	icge (1-4 of c	,,,	House	keeper	7	Motel	
d with	Completed	17. Father's Name (First, Middle, Last)				18.Mother's Nan	ne (First, Middle, Ma	iden Surname)	
215-0036 be filed within 7 ntal Hygiene riked other than	Be	Richard Lee Crippen,	Sr.			Elizabe	th Savage	3	
213 ould b I Men s mar	P	19a. Informant's Name/Relationship (Type, Prin	nt)					er, City or Town, State	, Zip Code)
MD d 2 sho Ith and n 27 is		Lisa Chandler/sister				1, Withams			
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Rem	oval from Sta		of Disposition (Name tory or other place)	of cemetery,	Date	20c. Location - City or	Town, State
Pager Pager ent o		4 Donation 5 Other Specify:	iovai iroini ott	"Cremat	cory of De	lmarva 7/	14/2008	Delmar, DE	
Baltimore, permit. Pages I an Oepartment of Hee Important: If ite Important: If ite Important of the Important of	1	21. Signature of Funeral Servic Lice see	/		22. Name and Ad	ddress of Facility I. Watson E	uneral Ho	ome	
0 89 1 1 1		Talana Mariot			I 1618 We	st Rd. Sa	lisburv.	MD 21801	A I
Physician /Medical		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused	the death. Do n	ot enter the mode of	dying, such as cardiad	or respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death
xaminer					ated by e	thanol int	oxication		Death
		b	or as a conse	equence or).					
	ě	it dity; roading to it.	or as a conse	equence of):					
-	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	or as a conse	auanca of):					
70 a sign		events resulting in death) Last							
executed ian and ial - transit	ical	X UNPENDED AMEN	NDED 23a	,27,282	ı−f, perME	, g882 8/1	4/08 TT		
60, ate be hysici	Physician/Med	IF FEMALE: 23c.	If yes, outcor	ne of pregnancy	,			23d. Date of deliver	y
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months?	Live birth	time of dooth	2 Fetal death	3 Ectopic preg	nancy	Month	Day Year
eath c	sic	1 Yes 2 No 9 Unknown 9	Unknown	time of death	5 Other (Specif	ý)			
The d	Ph)	Part II. Other significant conditions contrib		h but not resulti	ng in the underlying c	ause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death the certificate has been signed by the attending physicin pletely filled in by the funeral director, page 2 should be detached for use as the burn	by						1 Yes	2 No 3 Pro	bably 4 Unknown
ds, equir	Completed				•		24a. Was a		utopsy findings available completion of cause of
COr law law law law law law law law law law	mpl						autops perform	ned? death?	
Reifficat		25. Was case referred to medical			26	Place of Death (Chec		NO TO	63 2 110
/ita	o Be	examiner? [Hospital:	1 Inpatie	ent 2 ER/	Outpatient 3 DO	A Other Nur	sing Home 5 F	Residence 6 🗸 Othe	r: Scene
of \g Phy	\vdash	1 ✓ Yes 2 No 27. Manner of Death 28a	a, Date of Inju	iry 28b	. Time of Injury 28	c. Injury at Work?	28d. Describe h	ow injury occurred	
On endin	tion	1 Natural 5 Pending	d 7/11		nd 9:54 pm	1 Yes 2 X No	unk		
VISI or Att fter de birecti	ertification:		e. Place of Ir	njury - At home,	farm, street, factory, o		28f. Location (S	reet and Number or R	ural Route Number, City el Avenue
Divalor pital conurs al mars a	erti		pecify) 1	ound in	n water		Ocean C	ty, MD	- Avenee
Division of To the Hospital or Attending Phwithin 24 hours after death To the Funeral Director: After temperal Director: After temperal Director or Completely filled in by the funeral	alc	29a. Certifier 1 Certifying Physician: To	the best of m	y knowledge, d	eath occurred at the t	ime, date and place, a	nd due to the cause	(s) and manner as sta	ted.
To the within To the comple	Medical		basis of exa anner stated.	mination and/of			d at the time, date a		
	Σ	29b. Signature and title of certifier				License number		29d. Date signed (Mo	ыші, <i>⊔</i> ау, <u>теаг</u> ј
		1//(/`			O.C.M.E.		July 13, 2008	
OCME		30. Name and address of person who complete				Street, Baltimore,	MD 21201		
		300		cal Examin	. 6	ou eet, paitimore,	1VID 2 1201		
St. Regist	ate	31. Date filed (Month, Day, X991)	22. Registra	, orginature	Or all the second				

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0 6

2008

32. Pegistrar's Signature

			For State Registrar	State	of Ma	aryland		artmen <i>rtificat</i>				lental Hy	giene,	200	8	260	58
			1. Decedent's Name (First, Middle	e, Last)						-		2. Date of D	eath	Ve	er	3. Time of	Death
	Physici: Medic/		Carrie Sarah	Clutter								August	6, 2	2008 "	5	30:30	Дм
	Examin		4a. Facility Name (If not institution	-						Location of	of Death			County of I			
			Goodwill Mennon			- // /-	a filled at 1	Gran		If Under	24 Hre	0 D-1(D		rrett		(0)	-
	uneral		5. Social Security Number 232–78–7886	6. Sex 1 ☐ M 2 🔀	, -	e (In yrs. Ia 97		If Under Months		Hours	Min.	8. Date of B	7 19	11 P	Country	ylvan	r⊦oreign iia
	irector		Usual Residence of Decedent			- 9	, , , , ,					oury 2	., 15.		CIIID	y = va	
yland	MON		10a. State 10b. County			10c. City,	Town or L	ocation							10d	I. Inside Cit	y Limits
Man	는 전 도	tor	MD Garre	tt		Acc	ident									1 🛚 Yes	2 🗌 No
th the	or 28,	Director	10e. Street and Number					10f. Zip	Code				10g. Citi.	zen of Wha	t Country	/?	
th wi	238	al	419 S. Main St	•				2	1520				USA				
r dea	er me	Funeral	11. Marital Status	12. Was I	Decedent d Forces?	Ever in U.S	i. 13.	Was Dece	dent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Spen, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V	American White, etc		
s afte	o.	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes	es 2⊠ ,Give	No		1 🗆 Yes	2 X No	Specify:				Specify:			
hour	tural'	d be		t's Education	or Dates:	- 1	16a Doce	dent's Usu	al Occupa	ation			16b Kir	nd of Busin	Whi		
in 72	fedic	Completed	(Specify only highe	st grade complet		-)	(Give	kind of wo	rk done o se retired	luring mos)	t of worki	ng	100.10	na or basin	1933/11/04	31. y	
with	1	E O	Elementary/Secondary (0-12)	Collec	ge (1-4or 9 2	5+)		emake						wn Ho	ome		
E E	othe.	0	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	e, Maiden	Sumame)			
D D	ked ic ev	ToB	Thomas G. Phill	ips						Maud	de La	ntz					
2 should be filed within 72 hours after death with the Maryland	E H		19a. Informant's Name/Relations				19b. Maili	ng Address	(Street a	and Numbe	er or Rura	i Route Numi	ber, City or	r Town, Sta	te, Zip C	ode)	
and 2	1.27 i		Thomas H. Clutt	er/Son			Rt. 2	, Box	1.00	-B-3,	Ter	ra Alt	a, W	1 267	764		
8 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	reportant if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar months to multiply at once.		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Demoval fr	om Stata	re	ace of Disponentery, cre	osition (Nai matory or c	ne of other place	θ)	C	Date	20c. Lo	cation - Cit	y or Tow	n, State	
Pages	ury o		4 Donation 5 Other (S		om State	Garr	ett C	o. Me	m. G	arder	ns Au	ıg. 9,	2008	Oakla	and,	MD	
permit.	y port		21. Signature of Funeral Service	Licensee		1						man Fu				P.A.	
3 8 6	5 E E 8		W- Egu	1 leum	au)	P	.O. E	ox 2	75, 0	Grant	sville	, MD	2153	36		
/M	physician and ledical aminer transit	dical Examiner	Immèdiate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ьС	ho for as	a conseque a conseque a conseque	ence of):	Gron Drill	ica licati	sejs lie	foli	Lau	lur	fair	luo	yea Mo	rele
To the Hospital or Attending Physician: The law requires that the death certifics	ed by the attending pł detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Li 4 □ P	ve birth	of pregnan 2 Fetal t time of de	death 3	⊒Ectopic p ⊒ Other (sp					2	23d. Date o Month			/ear
that	deta	by Pt	Part II. Other significant conditi	ons contributing	to death b	out not resul	ting in the u	underlying o	ause give	en in Part I	١.	23e. Did	tobacco u	se contribu	ite to the	cause of d	eath?
ž ž	s been signed b should be deta											1	Yes 2	No 3[Probab	oiy 4 □U	Jnknown
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he ta	e has	E C										per	opsy formed?	dea	r to comp th? Yes 2		ause of
E E	ifficat or. p	Ö	25. Was case referred to medica	1						26 Place	e of Death	1 ☐ Yes	/-	10	Tes 2	□ No	_
/sicia	s cert	0	examiner? 1 ☐ Yes 2 【 No	Hospital:	I ☐ Inpatio	ent 2∏E	R/Outpatie	nt 3 🗆 D0	Othe			me 5□Res		S □Other ((Specify)		
- E	er thi	i.	27. Manner of Dath	28a. D	ate of Inju		28b. Time o		28c. Injury Work			28d. Describe					
ig f	r: Aft	atlo	1 Natural 5 Pendir 2 Accident investi	9	vicinii, ba	y roury	mary	М		Yes 2□	No						
or Atte	Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 286. P	lace of Injuited	jury - At hor c. (Specify)	ne, farm, st	reet, factor	y, office			28f. Location City or To	(Street and own, State		or Rural F	Route Num	ber,
e Hospita	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier (Check only one) Certifyii	ng Physician: To Examiner: On the	the best ne basis o manner st	f examinati	rledge, dear on and/or in	th occurred ovestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the	e cause(s) , date and	and manne place, and	er as stat I due to th	ed. he cause(s)
To th	To th	Me	29b. Signature and title of centric	ret c	r t	Lein	UN.		DZ		0			e signed (A)
	Sta	2 ate	30. Name and address of person May gave a 31. Date filed Month, Day, Year,	who completed Calls	eR,	death (Item	130:	Print)	awe	th	igh	way	Oa	hleen	ud,	UD 21:	550

			Amend 28f, perME,	Type or Print in Blag 882 8/27/08 TJ	ack Ind	delible Ink.	Ensure A	All Copies Mental Hy	Are I	Legible.	
		,	1 - State Registrar	Otato of Marylana	Cer	tificate of	Death	violitai i i j	Reg. No.		20050
dy		-	Decedent's Name (First, Middle, Last,)				2. Date of De	eath	2000	3. Time of Death
н	Physici /Medic		Robert D.	Christian				Month	27 Day	2008	1222 M
×	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deati	1	4c.	County of Death	1
	in a second results of the	Ш	9251 Lottsford Ro			Upper M				ince Ge	
	Funeral		5. Social Security Number 6. Sec	M 2DF	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	a <i>y, Y</i> ea <i>r)</i>	Cot	nplace (State or Foreign untry)
	Director	Ş. I	220-08-7864 Usual Residence of Decedent	35	170.			Nov 8,	19/2	. Wash	ington, DC
	yland iow at		10a. State 10b. County	10c. City, 1	Town or Loc	cation					10d. Inside City Limits
	a-fst ified	ctor	Maryland Prince Go	eorge's Uppe	r Mar	lboro					1 X Yes 2 □ No
	or 28 e not	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?
	4 within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medikal Examiner must be notified at		9251 Lottsford Ros		,	20774				ted Sta	
	er de	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	0-	 Race - Amer Black, White 	e, etc.
36	rs afte	by F	1 Tane Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	☐Yes 2XNo	Specify:			Specify:	frican merican
21215-0036	thou atura	pa	15. Decedent's Edu	cation		ent's Usual Occup			16b. Ki	nd of Business/I	
215	C , 0	plet	(Specify only highest grad	e completed) College (1-4or 5+)	(Give I life. D	kind of work done OO NOT use retired	during most of wor d)	rking			
21	filed within Hygiene. other than ent, the M	Completed	Elementally cocondary (c 12)	2 years	Auto	Sales			Se1	f Emplo	yed
pu	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	•		Surname)	
<u>yla</u>	2 should be filed of and Mental Hygin is marked other raumatic event, the	2	James R. Christ					ey White			
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty James R. Christia			g Address <i>(Street</i>					
di.	1 and Health	3	20a. Method of Disposition			sition (Name of	- DIIVE	Date		cation - City or	
Baltimore,	permit. Pages 1 and 2 s Department of Health al Important: If item 27 is any injury or other trau		1 🔀 Burial 2 □ Cremation 3 🗆 F	Removal from State cen	netery, crem	natory or other plac	i i			•	
ij	artme ortani Injury	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service ice	LILIE		lem. Ceme . Name and Addre					
Ba	permi Depar Impor any ir		- DIRWAG	Dong Salt	the state of the s	001 Benn					•
			23a. Part1. Enter the disease, or compl	ications that caused the death.					-	,	Approximate Interval Between
	Physician	S W	shock, or leart failure. List only or Immediate Cause (Final	ne cause on each line. a. Cunsket b	. 200 /	e a ten	16.	1		1	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequer		-e(/U	77-60	-(
111	Examiner		To the first of the late of th	o. =							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):						
	e executed cian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D							
60,	be ex cian a		and the state of t	Due to (or as a consequer	nce of):						
68760	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical		d							
×6	certifi ding se as	₩ We	IF FEMALE:	3c. If yes, outcome pf pregnanc	·V					23d. Date of deli	ven.
Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal do 4 ☐ Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)	/		1	Month	Day Year
P.O.	that the de led by the a detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown							
	uires that signed b d be deta	by Pi	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Records,	w requires been sign should be							1 🗆	Yes 2	No 3□ Pr	obably 4 □Unknown
900	aw re is bee 2 sho	Completed						24a. Was			topsy findings available
Ä	The lav ate has page 2:	mo						auto perf 1 Yes	ormed?	death?	completion of cause of 2 ☐ No
Vital	sician; Th certificate rector, pag	Be C	25. Was case referred to medical examined?				26. Place of Dea				
7	ys dir	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient		4 Li Nursing F	-		6 □Other (Spec	cify)
Division or	Affer I	ë ::	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	Bb. Time of Injury	28c. Injur Wor		28d. Describe	how injur	· •	elf-
Sic	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Plice of Jury - At home	1227		Yes 2 ₹No	1		•	word Pouto Number
Σ	or A after Direct in by	Certification:	4 Homicide determined	building, etc. (Specify)	ho.			City or To	wn, State	Number of AL	LArgo, MD
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my knowle	-		me, date and place	e, and due to the	cause(s)	and manner as	Hot 4E
	ne Ho 1 24 th ne Fui	Medical		ner: On the basis of examination and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier	10 1		29c. Licens	e number		29d. Dat	e signed (Monti	h, Day, Year)
			Sarvada,	1/2/420		1,500	53827	>	Ja	2 30	2008
9	181		30. Name and address of person who co	impleted cause of death (Item 2:	3a) (Type, F	Print)		r. 1	0		0
	0		SplvAder Dy	32. Registrar's Signatur	Hosp	1/72/	Urine	ممصر	X,	Mary	1 and
	Sta Registr		JUL 3 1 2008	Sz. negistiar s Signatur	A.		•		-/		

December Manual Plane Machine				State of Maryland / Dep	ertment of Health and Nertificate of Death		0000 0000
Juanita B. Cuminpham Superior State					Timeate of Death		
## Courty of Death The Test Prince (Prince studies) as whether any number) Silver Spring South Courty of Death Silver Spring South Courty South Number Silver Spring South Courty South Caroling South Caroling				Juanita B. Cunningham			Day Year
Second Second Number of Control Number of Cont					4b. City, Town, or Location of Death		
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Due to (or as a consequence of): Prepared Prepared	< E	Examiner		Sonoic			
Due to (or as a consequence of): d. Teaching a contribute to the cause of death program to the past 12 months? 1			ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
FEMALE: 23d. Date of delivery 23d. Date of death		ecure and transi	ami	Cause (Disease or injury that initiated events c. Pneumonia			
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Description of the page of the	5	een s	ted			1 ☐ Ye	s 2 ☐ No 3 ☐ Probably 4 € Unknown
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature 34. Page filed (Month, Day, Year) 35. Registrar's Signature 36. Certifier (Check only one) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	A TA	er deg	I I I I	determined 286. Place of Injury - At nome, farm, st	reet, factory, office	28f. Location (Str	reet and Number or Rural Route Number,
D62520 July 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marla D'Arbella 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Benistrar's Signature		rs after in led in	Cer	Full morniode building, etc. (Specify)		City or 10 wn,	, State)
D62520 July 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marla D'Arbella 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Benistrar's Signature	Hoen!	e Funer	dical	Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as stated. tte and place, and due to the cause(s)
D62520 July 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marla D'Arbella 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Benistrar's Signature	To th	within To th comp	Me		29c. License number	29	Od. Date signed (Month, Day, Year)
Dr. Marla D'Arbella 1500 Forest Glen Road Silver Spring, MD 20910				► Withthela	D62520		July 27, 2008
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			1 - State of N	Maryland / Depa <i>Cel</i>	artment of Health rtificate of Deat	n and Mental Hy h	giene Reg. No. 2008	26061
	Dhysisi		Decedent's Name (First, Middle, Last)			2. Date of De	ath	3. Time of Death
	Physici /Medio		Addie N. Curtis			07 Manth	25 2008	2:30 PM
	Examir	er	4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Locatio	on of Death	4c. County of Deat	h
-	Formul		HRC Manor Care 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Silver Sprin	er 24 Hrs. 8 Date of Bir	Montgomer	y hplace (State or Foreign
	Funeral Director		579 60 5582 1□ M 2027F	96 Yrs.	Months Days Hours		y, Year) Co	untry)
	pu ,		Usual Residence of Decedent			111711.	/11 200	
	arylar shov	7	10a. State 10b. County MD Montgomery	10c. City, Town or Lo				10d. Inside City Limits 1
	the M	Director	10e. Street and Number	DILVOI DP	10f. Zip Code		10g. Citizen of What Co	
	3a or	Ö	2501 Musgrove Road		20904		United Stat	-
	death ms 2	Funeral	11. Marital Status 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hispanic Of Yes, specify Cuban, Mexic			rican Indian,
21215-0036	within 72 hours after death with the Maryland jeine. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	þ	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date	DNo.	1 □Yes 2 DNo Speci		Specify: B1a	
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during me	aget of working	16b. Kind of Business/	
121	C 3 (3)	du	Elementary/Secondary (0-12) College (1-4d	r 5+) life.	DO NOT use retired)	ost or working	Bureau of E	ngraving
Q 7	it ibe		12 17. Father's Name (First, Middle, Last)	Print		ther's Name (First, Middle,	Maiden Surname)	
Maryland	0 0 0 0	To Be	John Johnson			ie V. Johnson	· · · · · · · · · · · · · · · · · · ·	
ary	de E	۴	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Nun			Zip Code)
Σ	1 end 2 Health a iem 27 is		Louis F. Nelson SON	327 0	nieda St. NE	Washington,	DC 20011	
ore	iges 1 enc nt of Healt if item 2: or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Star	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	Date	20c. Location - City or	Town, State
Baltimore,	t. Pag rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)	Mt/. Olive		07/31/2008	Washington	
Bal	permit. Pages 1 Department of P Important: If ite any Injury or ot once.		21. Schatur Funeral Service Lonsee	30	2. Name and Address of Fac 05 12th St. N	NE Washington	n,DC 20017	l Home,LLC
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dying, such	as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Andrew .	Physician		Immediate Cause (Final disease or condition resulting in death) a. MYOCAR	DIAL INFARC	TION			Onset and Death
7	/Medical Examiner		Due to (or a	as a consequence of):				
		er		CLEROTIC HE. as a consequence or):	ART DISEASE			
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
, 0	e exe sian ar urial-ti	Ex		as a consequence of):				
8760,	icate be executed physician and the buriat-transit	dical	d					
		/Me	IF FEMALE: 23b. Was decedent program 23c. If yes, outcome	ne of pregnancy			004 8-4-4	
Вох	leath atter	ciar	in the past 12 mosths?	n 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
P.O.	The law requires that the death certificate has been signed by the attending oage 2 should be detached for use as	Physician/Me	9 Unknown 9 Unknown					
S, F	ss tha gned se det	y P	Part II. Other significant conditions contributing to death	but not resulting in the ui	nderlying cause given in Par	rt I. 23e. Did t	obacco use contribute to	the cause of death?
ord	w requires to be a signal should be a	ted	CEREBROVASCULAR ACCIDENT				Yes 2 No 3 Pr	robably 4 Unknown
ě	law r has b	Completed by	FAILURE TO THRIVE			24a. Was	prior to	topsy findings available completion of cause of
ᇤ	ilcian: The certificate ector, pag						rmed? death? 2 ☑ No 1 ☐ Yes	2 🗀 No
ξ	siciar certif rectoi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa		0.1	ace of Death (Check only o		
ō	Attending Physician: r death. ector: After this certific by the funeral director, I	n: To	27. Manner of Death 28a. Date of I	atient 2 ER/Outpatier	28c. Injury at	Nursing Home 5 Resident	dence 6 ∐Other (Spe how injury occurred	cify)
<u>.</u>	ath. r: After e funer	atio	1 Natural 5 Pending (Month, I 2 Accident investigation	Day, Year) Injury	Work? M 1 ☐ Yes 2 [□No		
Division of Vital Records,	l or Attene after death Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	njury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (S City or Tox	Street and Number or Ru	ıral Route Number,
	ospital o hours aft uneral Di							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	s of examination and/or in	n occurred at the time, date vestigation, in my opinion, d	and place, and due to the death occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the He within 24 To the Fit complete	Me	29b. Signature and little of ortifier		29c. License numbe	er	29d. Date signed (Mont	h, Day, Year)
			1 Menli	-	D19609		July 28	2008
0	(3)		30. Name and address of person who completed cause of RAMAN TULY 3503 PERRY STR	f death (Item 23a) (Type, EET MT.RAINI)
	Sta	te			, Lance			
	Registra		JUL 3 1 2008 Blown	strar's Signature				

Box 68760. P.O. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital o within 24 hours af To the Funeral Di

24b. Were autopsy findings available prior to completion of cause of death? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🔾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Stertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number D 26064 29d. Date signed (*Month*, *Day*, *Year*)

AUG - 04 - 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIPYASAGAR ANMANGANDLA

10583-THEODORE GREEN BLVD PLAINS, MD - 20695

State Registrar

Certification:

31. Date filed (Month, Day, Year) AUG 0 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26063 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Nelson Lamont Copper July 27 2008 6:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis HealthCare -The Pines Talbot Easton If Under 1 Year If Under 24 Hrs.

Hours Min. 8. Date of Birth May 12, 1946 5. Social Security Number Sex 11 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland May 214-46-4913 62 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f sho 1 Yes 2 No Director MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21601 343 Port Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. Specify: Black 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foundry Worker Metal Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude McDaniels Charles Benson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Maple Avenue Essex, MD 21221 Anthony R. Copper/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/29/08 Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tepetocellular carcomome **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 20 No within 24 hours arter construction To the Funeral Director: After this construction of the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Other: ဥ Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) ROWLLYMD 610 1)07 State

and manner stated.

Registrar

29a. Certifier

Medical

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

		_	1 - For State Registrar	State of Ma	ryiand / L	-	tificate of			F	Reg. No. 2	008	26064
100	Physici /Medio		Decedent's Name (First, Middle, Las) Jorge Cab	rales					2. Date of Dea Month July	Day 28	Year 2008	3. Time of Death 7:30 a.M
i	Examin Funeral Director		4a. Facilify Name (If not institution, give 3000 Gazebo C 5. Social Security Number 577-66-2736	ourt	(In yrs. last bir 79	rthday) Yrs.	4b. City, Town, o	Silver If Under Hours	Spri	ng 8. Date of Birti (Month, Day December	h /, Year)		nery lace (State or Foreign try) Ecuador
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	cation			December	10,1720		Od. Inside City Limits
	the Mary 28a-f sh notified	Director	Maryland Montg	omery			10f. Zip Code	Silver	Spri		10g. Citizen	of What Cour	1 ☐ Yes 2 🖪 No
	eath with s 23a or nust be		3000 Gazebo C	Court 12. Was Decedent E	vor in II S	12 1/	Van Danadast of L	20904		anify Van ar Na	14 5	U.:	S.A.
5-0036	ours after d ral", or Item Examiner i	by Funeral	11. Marital Status 1 □ Never Married 2 A Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cub ▼Yes 2□ No	an, Mexica Specify:		Rican, etc.)	E	Black, White,	
21215-0	illed within 72 hours after death with the Maryland Hygiene. Hydiene in atura!" or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-		. Deced (Give I life. D	cedent's Usual Occupation ve kind of work done during most of workir . DO NOT use retired) Chef			ding 16b. K		Kind of Business/Industry Food Service	
and 2	es 1 and 2 should be filled of Health and Mental Hygii f item 27 Is marked other or other traumatic event, it	Be	17. Father's Name (First, Middle, Last)		!				er's Name	e (First, Middle,		name)	
Maryland	2 should and Me is mark aumatic	ို	19a. Informant's Name/Relationship (7	Sabrales Type. Print)	195	o. Mailin	g Address (Street	and Numb	er or Rur		a Estra er, City or To		Code)
re, ≥	s 1 and f Health item 27 other tr		Maria Cabrales 20a. Method of Disposition		20b. Place o	f Dispos	Gazebo Cou	- ;		Spring, M		20904 on - City or To	own, State
altimore,	permit. Pages Department of I Important: If its any Injury or o once.		1 Burial 2 Bernation 3 4 Donation 5 Other (Specify		1	inco	1n Cremato	ry		31/2008	Brentw	ood, Mar	yland
ga	Depar Impor any Ir		21. Signature of Funeral Service Licent	h Fran		Hi	, Name and Addre L nes-Rinal d L 800 New H a	li Fune	ral H			ng, Mary	yland 20904
,	Dhysician /Medical Examiner bhysician and bhysician and sthe parial-transit	edical Examiner	23a. Part 1. Enter the discase, or tomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alzheimer's Disease Tears Alzheimer's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underfying cause, cursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Interval Between Onset and Death
. Box	death certif e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death		Ectopic pregnanc Other (specify)	су			23d. Date of delivery Month Day Yea		*
ν [ine law requires that the te has been signed by the age 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknow			
		Completed									. Was an autopsy performed? Yes 2 ≅ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	iding Pnysician: h. : After this certifica funeral director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Constitution 1 Inpatient 2 EP/Outpatient 3 DOA Constitution 1 Inpatient 2 EP/Outpatient 3 Inpatient 2 EP/Outpatient 3 Inpatient 3 In							h <i>(Check only o</i> rme 5 🛭 Resid		Other (Specif	y)
	or Attending Protected to the function of the	ertification:	00 D. M. (D. W.)									d Route Number	
	F 8 F C	O	4 ☐ Homicide determined 29a, Certifier 1 ☒ Certifying Phy	building, etc.	(Specify)			me data a		City or Tow	n, State)		
:	o the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Exam	niner: On the basis of and manner state	examination ar	nd/or inv	estigation, in my	ppinion, dea	ath occur	red at the time,	date and plac	ce, and due to	tated. the cause(s)
	with con	Σ	29b. Signature and title of certifier				29c. Licens	e number 09834				ined (Month, July 29	
•	>		30. Name and address of person who o				Print)			_1 0000		July 25	, 2000
457	Sta Registr		Barry Rosenbaum, 31. Date filed (Month, Day, Year)	32 Registra	arragut /	_	ie, Kensing	con, M	aryla	na 20895			

	State of Maryland / De	ertificate of Death		eg. No.			65
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month July	h Day 28	Year 2008	3. Time of De 1715	eath M
/Medical	Laura B. Clark	4b. City, Town, or Location of Death	July	4c. Count			
Examiner	4a. Facility Name (If not institution, give street and number)	Silver Spring			rreser	gomery	
	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Voar)		lace (State or F	oreign
neral ector	578-52-0597 1□ M 2 ^M F 71 Yrs	Months Davs Hours Min.	May 5,	1937		exas	
any injury or other traumatic event, the Medical Exprising trusts be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			1	0d. Inside City	Limits
jo jo	Maryland Prince George's	Beltsville				1 □Yes 2	X No
Director	10e, Street and Number	10f. Zip Code	1	0g. Citizen of	What Cour	ntry?	-
0	11316 Cherry Hill Road, #102	20705			U.S	5.A.	
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ		
Z	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No	1 □Yes 2 No Specify:	,	Speci			
b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					White	
Completed	(Specify only highest grade completed)	ecedent's Usual Occupation live kind of work done during most of work		16b. Kind of B	Business/In	dustry	
Į de	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		Montgo	mery Co	ounty Pol	ice
S	12	Police Administration 18. Mother's Nam	e (First, Middle, I			ouncy_roz	
Be	17. Father's Name (First, Middle, Last)	to. Mother 3 Nam					
은	Roy Butler	ailing Address (Street and Number or Ru		th Black		Code)	
1							
		9 Cliftonbrook Lane, Sil	Date	20c. Location			
11.	20a. Method of Disposition 1 ☐ Burial _2 ▼ Cremation 3 ☐ Premoval from State	crematory or other place)					
Ш	4 □ Done tion 5 □ Other (Specify) Fort Lin		4/2008	Brentwo	od, Mai	ryland	
	21. Sig ture i Funeral Service Libensee	22. Name and Address of Facility Hines-Rinaldi Funeral F	lome, Inc.			1 1 000	201
	Three M. Jour	11800 New Hampshire Ave			g, Mar	Approximate	
	23a. Part 1. Enter the dist ase, or comflications that caused the death. Do not shock, or heart allule. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory an	1651,		Interval Betw Onset and De	/een
1	Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary						
ı	Due to (or as a consequence or)						
		piratory Failure					
nin.	cause. Enter Underlying Cause (Disease or injury Amyotropic Late				7.5		
Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of)						
न्न							
gipa	u						
Physician/Medio	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	0			Date of deliv		
cial	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 1 □ Wes 2 ☒ No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Y	'ear
ıvsi	9 Unknown						_
		he underlying cause given in Part I.				the cause of de	
d b			1 🗆 \	Yes 2 X No	3 □ Pro	obably 4 □ U	nknown
Completed			24a. Was	an 24	b. Were au	topsy findings a completion of ca	available
1 8				rmed?	death?	2 ☐ No	luse of
		26. Place of Dec	1 □ Yes th (Check only o		1 🗀 162	2 1110	
Be		Othor:			Other (Spec	cify)	
P	1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outr 27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe			,,,,,	
li i	1. Matural 5 □ Pending (Month, Day, Year) Inj	ury Work? M 1 ☐ Yes 2 ☐ No					
fica	2 Accident investigation 3 Suicide 6 Could not be determined determined building als (Specify)	n, street, factory, office	28f. Location (Street and Nu	mber or Ru	ral Route Num	ber,
Certification: To	4 ☐ Homicide determined building, etc. (Specify)		City or Tox	WII, State)			
		death occurred at the time, date and place	e, and due to the	cause(s) and	I manner as	s stated.	.,
Medical	29a. Certifying Physician. To the basis of examination and one) Certifying Physician. To the basis of examination and manner stated.	or investigation, in my opinion, death occ	urred at the time,	date and plac	e, and due	to the cause(s	
Me	29b. Signature and title of certifier	29c. License number		29d. Date sig	gned (Montl	h, Day, Year)	
	I Walt	D65953		Ju1	y 29,	2008	
	30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print)					
	Adaku Chimtua Onukogu, M.D., 1500 Fore	est Glen Road, Silver Sp	ring, Mary	yland 20	910		
	20 40 10 10						
State	31. Date filed (Month, Day, Year) 32. Signature	1. 65.					

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of IVI	aryiana / Dep <i>Ce</i>	ertificate of			^{ene} 200	18	26067		
	Physici		1. Decedent's Name (First, Mide	dle, Last)				2. Date of Death Month		ear	3. Time of Death		
	/Medi		Richard James	Costopoulos				July 28,			12:30 p M		
	Examir	ner	4a. Facility Name (If not instituti			-	or Location of Death		4c. County of				
	-		Suburban Hospi 5. Social Security Number		je (In yrs. last birthda		thesda If Under 24 Hrs.	8 Date of Birth	Montg		e (State or Foreign		
	Funeral Director		214–70–3979 Usual Residence of Decedent	tx□M 2□F 53	Yrs.	Months Days		8. Date of Birth (Month, Day, Feb. 27,			te (State or Foreign) Iton, DC		
	yland now	10a. State 10b. County 10c. City, Town or Location									Inside City Limits		
	e Mar Ba-f sl	Director	Maryland Mor	ntgomery	01	ney				1 ☐ Yes 2 🙀 No			
	or 28	Dir.	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country	?		
	ath w	<u>ra</u>	3753 Carrisa La			20832			USA				
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, if a Marical Evaning must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Ever in U.S. 13	If Yes, specify Cuban, Mexican, Pue		ecify Yes or No- Rican, etc.)		American Indian, White, etc. White			
5-0	72 hor	eted	15. Decede	nt's Education est grade completed)	16a. Dec	edent's Usual Occu	pation during most of working	10	6b. Kind of Busir	ness/Indus	try		
121	within jene.	Completed	Elementary/Secondary (0-12)	College (1-4or s	life	DO NOT use retire	ed)						
	filed w Hygie tther t		17. Father's Name (First, Middle	22	P	resident	18 Mother's Name			Truck Fquipment Distri			
Maryland	should be filed and Mental Hygi marked other imatic event, t	To Be	Homer William (Emilda Mar						
Z	should I and Men is marke	=	19a. Informant's Name/Relation	-	19b. Ma	ling Address (Stree	t and Number or Rura			ate. Zip Co	ode)		
ž	nd 2 alth a 27 is	b	Dorothy J. Costor	oulos/Wife			Olney, MD 20		,,,,,				
Baltimore,	# O - 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Cohe of Heavest Augus				0c. Location - Cit	•			
altii	# 문문을		21. Signature of Funeral Service				tery ; 200 ess of Facility Collins Fune		_Silver S	oring,	Maryland		
ä	permi Depar Impor any Ir		1 James	2 Down	I .		ity Blvd, W.			20901			
	Physician pe executed db Medical and American and as the burial-transit	al Examiner			Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	4 6AS1	THO ESOPH	496EAC	TUNCT	POP)	set and Death
	tificate ig phy as the	ledical		d				7.5					
.O. Box	requires that the death cer been signed by the attendin hould be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	су		23d. Date o Month	,	y Year				
rds, P.	w requires that s been signed should be det	by	Part II. Other significant condit	ven in Part I.		acco use contribu ; 2 ☐ No 3[ite to the o						
l Rec	The law ate has t	Completed							24a. Was an autopsy performed? 1 □ Yes 2 ▼ No 1 □ Yes 2 □ No				
Z.	Physiclan: r this certifica ral director, p	Be	25. Was case referred to medica examiner?	Hospital:		Oth	26. Place of Death						
of	Phys or this oral dii	: To	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER/Outpatient 28b. Time	SIL SELDOA	4 Li Nursing Hor	ne 5 Resider		(Specify)			
on	Attending I ir death. ector: After by the funer	atior	Natural 5 Pendi 2 Accident invest	/Administration Plan	y, Year) Injury	Wor	ḱ? lYes 2 □No	.00. 20001130 1101	injury occurred				
Divis	al or Atte safter des l Director d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could	not be nined 28e. Place of Injuined building, etc	treet, factory, office	2	8f. Location (Stre City or Town,	eet and Number o State)	t and Number or Rural Route Number, tate)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier Check only one) Certify 2 Medica	ng Physician: To the best Examiner: On the basis o and manner sta	f examination and/or	ath occurred at the tinvestigation, in my	ime, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and mann te and place, and	er as state I due to the	ed. e cause(s)		
	To th withii To th comp	Me	29b. Signature and title of certific	er O		29c. Licens			d. Date signed (A	-			
	25		> Mua	Fragon		023	308		ruly 20	7, 2	800		
	40		30. Name and address of person VICTOR M	who completed cause of d. PRIEGO, M.	eath (Item 23a) (Type D • 6420	, Print) ROCK LEV	GE DR.	BETH	FULY 20	no.	20817		
	Sta Registr		31. Date filed (Month, Day, Year,		ar's Signature	de	-		-				

COSTOPOULOS, RICHARD 7/29/08 1230 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26068

Kimberly Y. Diaz-Rivas

			For State		Cen	tificate of	Death					eg. No.		10.7	f Don't	
	hysicia Examir	n/	. Decedent's Name (First, Midd KIMBERLY Y. I		5		-				Date of Dea Month August 3,	Day 2008	Year	1	Time of Death	
		4	la. Facility Name (if not instituti	on, give street and r			4b. City, Tov Wheato		cation of	Death	-		. County of Nontgom			
			East Randolph Road	6. Sex	7. Age (In yrs. la	est hirthday)	If Under		If Under	24Hrs.	8. Date of Bi		_	-	ace (State or	
	ineral rector	1	5. Social Security Number		7. Age (III)13. Ic		Months	Days	Hours	I Min. 1	Novemb				El Sal	lvade
	00.0	- -	NONE Usual Residence of Decedent	1 M 2 X F	<u></u>	19 Yrs	··				Novelli	JEI_	27,			
	any		10a. State 10b. County		10c. City,	Town or Local	tion								d. Inside City	
pu	*	_	Maryland Mon	tgomery	Rock	ville									X Yes 2	No
faryla	28a-f	Director	10e. Street and Number	<u> </u>	<u> </u>		10f. Zip C							at Country?	,	
the N	ms 23a or 28a-f show be notified at once.		4414 Independe				2085			0/0	'6 Non an N		Salva		Indian, Black	
h with	ems 2.	Funeral	11. Marital Status 1 X Never Married 2		ecedent Ever in U. Forces?	S. 13. W	as Decedent Yes, specify	of Hispa Cuban, N	anic Origi Mexican,	Puerto Ri	cify Yes or No ican, etc.)	0-	White		iliulali, black	`'
er deal	Hygiene. other than "naturat", or iter the Medical Examiner must			1 Yes		1X	Yes 2	No	specify:	Sal	vadori	ian	Specify: V	Nhite	Hispar	nic
Irs afte	turat"	함	15. Decedent's Education (Sp	or Dates:		16a. Decede	nt's Usual O	ccupation	n (Give k	kind of wo	rk done	16b.	Kind of Bu	siness/Indu	stry	
; 72 hou	tygiene. other than "natural the Medical Examín	mpleted	Elementary/Secondary (0-12	2) College	(1-4 or 5+)		nost of worki	ng life. L	ONOT	use retire	a)	1 0 -	1 4			
036	r tha	ם	11th			Studer	nt ———	1 44			First, Middle,		udent			
5-0	Hygid othe	ပို	17. Father's Name (First, Middl Lorenzo Diaz								ras de					
D 21215-0036 should be filed within 72 hours after death with the Maryland	Jental narke event	o Be	19a. Informant's Name/Relation	_		19b. Mailir	ng Address	(Street	and Num	ber or Ru	ıral Route Nu	ımber, C	City or Tow	n, State, Zi	p Code)	
2 shou	and P 27 is r matic	-	Jesus Alfredo		other)	5027	Niaga	ra R	Road	Col1	ege Pa					
e, 7	Health item	-	20a. Method of Disposition 1 X Burial 2 Cremati	. X		Place of Dispo	ther place)				Date			City or To		
nor	ent of nt: If		1 X Burial 2 Cremati		State	anta To	eresa	Ceme	te	Aug/	20/08	La	Paz	, E1 S	Salvad	or
altir	Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medici		21. Signature of Funeral Servi	ce Licensee	V/=	22.	Name and A	Address	of Facility	Sant	a Cru	z Fu	inera.	les La	atinos	, In
Be B	79 E E		23a. Part I. Enter the disease,	h By	tout	61	00 Ken	nedy	ST.	N.V	V. Wash	ingt	on.).C.	20011 Approximate	Interval
	sician ledical		23a. Part I. Enter the disease, failure. List only one cau	se on each line.		n, Do not enter	the mode of	i dyirig, s	ucii as c	ar grac or	respiratory a		10011, 01 110		Between Ons Death	set and
	aminer		Immediate Cause (Final disea or condition resulting in death		njuries s a consequence o	of):								-		
				b.	s a consequence (
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau		s a consequence	of):										
		Examine	(Disease or injury that initiated events resulting in death) Las	d C.	s a consequence	of):										
cuted	nd transit			d												
• exe	ician a	dica	UNPENDED	AMENDE	D											
Division of Vital Records, P.O. Box 68760,	g physician and the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant i		es, outcome of pre	gnancy	Fetal death	3	Ectopi	ic pregnar	ncy	2	3d. Date o	f delivery Day	y Y	ear
Box 68	e attending for use as	ciar	past 12 months?	4 Pr	egnant at time of d	1 4 to	Other (Spec					-				
Bo)	the att	hysi	1 Yes 2 No 9 🗸	9 u	nknown						230 Die	d tobacc	o use cont	ribute to th	e cause of de	eath?
o į	res mar me de signed by the	by P	Part II. Other significant con	iditions contributir	ng to death but not	resulting in the	e underlying	cause g	iven in P	ап I.			✓ No 3			nknown
S, H	urres n sign Id be	ed t									24a. Wa	as an	24b.	Were auto	psy findings a	available
ord	law requir has been s 2 should l	를										topsy rformed	?	death?	mpletion of ca	_
Division of Vital Records, P.O.	ine i icate h page	Completed	L					00 Di	-f.D#	(Check o		s 2 🗸	No	1 Yes	2	No
tal	ysician: The lis certificate director, page	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpatie			Other4		g Home 5	Resi	idence 6	✓ Other: S	Scene	
j Ž	Physic er this eral dir	-	1 ✓ Yes 2 No 27. Manner of Death	28a. D	Date of Injury	28b. Time			y at Wor	rk?	28d. Descrit	be how i	injury occu	rred		
o no	nding Phy th r: After tl ie funeral	ioi	1 Natural 5 F	ending	lonth, Day,Year) 3, 2008	1610 hrs		1_ \	res 2 ♥	No	Passenge	er auto	auto co	MISION		
isic	r Atte er dea irecto	ficat		ould not be 28e.	Place of Injury - At	home, farm, s	treet, factory	, office b	uilding, e	etc.	28f. Locatio	n (Stree	et and Num	ber or Rura	al Route Numi	ber, City
ے آ	iital o urs aft rral Di	Certification:	4 Homicide	letermined (Spe	cify) Local Str										Wheaton,	MD
1	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	E	29a. Certifier (Check only 1 Certifyin	g Physician: To the Examiner:On the ba	best of my knowle	edge, death oc	curred at the	e time, da	ate and p	lace, and	due to the c	ause(s)	and mann	er as stated	t. cause(s)	
	Fo the vithin Fo the	edical	one) 2 Medical 1	and mann	isis of examination ner stated.	and/or invest					at the time, do				th, Day, Year)	
	- > - 0	Σ	29b. Signature and title of ce	rtifier			29	O.C.	e numbe MiF	31			ugust 4		n, Day, 1001/	
			Moss			-05		0.0.	· • · · · ·							
			30. Name and address of per Ana Rubio MD.	rson who completed Assistant Medic		em 23a) 111 Pen i	n Street. I	Baltimo	ore, MI) 2120	1					
		State	i		2 Registrar's Sign											
	Regi		(3 + 1)	3 2008	alegue.	K A	BARES									
рнмн	17 Rev 1	/2001		•		ORIGII	NAL					00	OME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26069 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 28, Day 2008 Year Thomas Joseph DiVenti 3:28 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3254 Normandy Woods Drive Apt. F Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 13, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Days Hours Min. Maryland 218-88-2416 45 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 USA 3254 Normandy Woods Drive Apt. F 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Salesman Automobile Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip Anthony DiVenti Carole Ann Dodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5011 General Branch Ct. Sharpsburg, MD 21782 Carole A. DiVenti/mother Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State Chesapeake Crematory: 07/30/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Selvice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tastatic months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

law requires that the death certificate be executed

certificate has

After this certific funeral director,

page

Box 68760,

P.O.

Division of Vital Records,

Physician: The

the Hospital or Attending To the Hospital or recommend within 24 hours after death.

To the Funeral Director: After a funeral or filled in by the funeral or funer

Physician

Examiner

10a. State

MD

Funeral

Director

28a-f show

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23a

Items ;

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"natural"

Hygiene.

it and 2 should be filed wi Health and Mental Hygier tem 27 Is marked other th

permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once.

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

/Medical

Examiner physician and s the burial-trans Physician/Medical attending p ed by the detached signed l

2

Completed

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Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

	1 ☐ Yes	
24a	. Was an	

autopsy performed? 1 ☐ Yes 2√2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25.	Was case referred to medical examiner?
	1 Yes 2 No
27	Manner of Death

5 Pending investigation 6 Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 💢 Natural

2 Accident

4 Homicide

3 ☐ Suicide

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

4113

July 29, 2008

29d. Date signed (Month, Day, Year)

Clement B. Knight, M.D. o completed cause of death (Item 23a) (Type, Print) Schmuckler Hdam 11065 CHIE PATURENT PKWY Columbia, MS 21044

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Day, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 d 183 PM 2009 JANICE MOORE DAWKINS 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Dorci Cambridge Genero HOSSHO Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🕱 F 219-36-6681 1938 MARYLAND FEB.15, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No **QUEEN ANNE** CENTREVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21617 119 WATSON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify Specify: WHITE 3 X Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUBLISHING COMPANY BOOKKEEPER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, JAMES RICHARD MOORE DORIS USILTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 119 WATSON ROAD, CENTREVILLE, MD 21617 MELISSA GARRETTSON/ DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MD 7-30-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Land 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. homas rentrea 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Acut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown phlymania 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

/Medical Examiner law requires that the death certificate be executed sician and burial-trans P.O. Box 68760, attending physician for use as the buria signed by the a d be detached f Records, certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica

Physician

Physician/Medical Completed funeral director, Be Certification: To

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, it is Medical Examination in its invitibula.

2 should be filed within 72 hours after deat and Mental Hygiene. is marked other than "natural", or items?

Janice M

Jawkins

3altimore, Maryland 21215-0036

within 24 hours a To the Funeral C completely

filled in by

29b. Signature and title of certifie

Labib Ahmed

1 Natural
2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

Labib

5 Pending investigation

6 ☐ Could not be

and manner stated.

29c. License number

0065528

1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d Date signed (Month, Dav. Year) 08 9.00A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Bym St.

31. Date filed (Month, Day,

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 200

2607

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23° **Physician** 2008 12:01PMM JULY EVELYN LOUISE DAVIS /Medical 4c. County of Death 4a. Fadlity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2**X** F 86 Director 188-20-9631 APR 16,1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notifled at XXYes 2 □ No Director TALBOT EASTON MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 39 KENSINGTON DR. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes X No Specify Specify: WHITE 3 Vidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) ELEMENTARY EDUCATION 12 TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Be FLORENCE GOLDEN ဥ LEROY EDKINS traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 519 ACADEMY ST., HURLOCK, MD 21643 JONATHAN H. DAVIS/SON other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) SPRING HILL CEMETERY 7/29/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN F. MERCERON 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacl. line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2□No 1∏ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient _2**_**1√10 Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division or Attending 5 ☐ Pending investigation 1 Natural Injury after death.

Director: Af in by the fur 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR. M.D., 501 DUTCHMANS LANE, EASTON, MD 21601 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JUL 2 8 2008

2. Date of Death

28

2008

Montgomery

4c. County of Death

July

4b. City, Town, or Location of Death

Silver Spring

6:45 a_M

For State Registrar Amend #5, perInf G882 8/18/08 Certificate of Death

Nora Rachel Eakin

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

2000 Flint Hill Road

Physician

/Medical

Examiner

Funeral Directo

1	5. Social Security Number		ge (In yrs. last birthda		Year Days	If Under	24 Hrs. Min.	8. Date of Bir	h v. Year)	9. Bir	rthplace (State or Foreign country)		
	285-10-44609	1 □ M 2 🔀 F	89 Yrs	Days	riouro		November		8	Ohio			
٦	Jsual Residence of Decedent												
	10a. State 10b. Cou	nty	10c. City, Town or	Location							10d. Inside City Limits		
용	Maryland	Montgomery			S	ilver	Sprin	ng			1 ☐ Yes 2K No		
ire	10e. Street and Number			10f. Zip (Code				10g. Citizen	of What C	ountry?		
<u>a</u>	2000 Flint	Hill Road				2090)6			U.	S.A.		
Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 1	3. Was Decede If Yes, speci	ent of His	spanic Ori	gin? (Spe	ecify Yes or No	. 14.	Race - Am Black, Whi	erican Indian,		
	1 ☐ Never Married 2 🔀 N		No	1 ☐ Yes 2		Specify:		1 110411, 010.)			ne, etc.		
by	3 ☐ Widowed 4 ☐ Divord	ced Year or Dates		10163 2	E3 140	apecity.			Spi	ecify:	White		
Completed	15. Deced	dent's Education ghest grade completed)	16a. De	ecedent's Usual live kind of work	Occupa	tion	t of worki	ina	16b. Kind o	f Business	s/Industry		
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Į	12			H	lomem	aker				Dom	estic		
Be (17. Father's Name (First, Midd	dle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden Sur	name)			
L P	Scot	t Taylor					N	lora Step	hens				
	19a. Informant's Name/Relation	onship (Type. Print)	19b. Ma	ailing Address (Street a	nd Numbe	er or Rura	al Route Numb	er, City or To	wn, State,	Zip Code)		
	Birch H. Eak	in - Spouse	20	00 Flint	Hi11	Road,	Silv	er Sprin	g, Mary	land 2	0906		
	20a. Method of Disposition		20b. Place of Dis	sposition (Name	e of			Date			r Town, State		
	1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Othe	on 3 Removal from Stat	9 4	crematory or ott coln Cres		i	08/02	2/2008	Rrantw	ood M	Maryland		
1	21. Signature of Funeral Serv	$\overline{}$	POIL DIE	22. Name and				.72000	DICHEW	, II	ar y rand		
	DA	100 200		Hines-Rin	aldi	Funer	ral Ho			3.4	. 1 . 1 2000/		
	220 Part Enter the decree	or complications that course								ng, ma	ryland 20904		
	23a. Part1. Enter the dease shock, or heart failure.	List only one cause on each	line.	enter the mode	OI UYIII	, such as	calulac	or respiratory a	rest,		Approximate Interval Between Onset and Death		
	disease or contition Acute Myocardial Infarction Immed												
	resulting in death)	Due to (or a	s a consequence of):										
	Sequentially list conditions by Hypertension												
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):												
a i	cause. Enter Underlying Cause (Disease or injury that initiated events c.												
Ä	resulting in death) Last Due to (or as a consequence of):												
g		d				_							
edi													
ted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date or										elivery		
icia	in the past 12 months? 1 Veg. 2 No. 4 Pregnant at time of death 5 Other (specify)										Month Day Year		
Jys	9 ☐ Unknown	9□Unknown											
<u>-</u>	Part II. Other significant cond	ditions contributing to death	but not resulting in the	e underlying ca	use give	n in Part I.		23e. Did t	obacco use	contribute t	to the cause of death?		
Q P								10	Yes 2. ₽.N	o 3□F	Probably 4 □Unknown		
ete								11					
Comple								24a. Was	an 2	4b. Were a prior to death?	autopsy findings available completion of cause of		
Ö	performed? de 1										s 2 No		
Be	25. Was case referred to med examiner?				1.		of Death	n (Check only o	ne)				
2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpa	ient 2 ER/Outpat	tient 3 DOA	Othe	r: 4 □ Nu	rsing Ho	me 5 🔼 Resi	dence 6	Other (Sp.	ecify)		
	27. Manner of Death 1 X Natural 5 ☐ Per	28a. Date of In (Month, D	jury 28b. Time <i>ay Year</i>) Injur	e of 28	c. Injury Work	at ?		28d. Describe	now injury oc	curred			
atic	2 ☐ Accident inve	estigation		М		′es 2 🗌	No						
1		uld not be ermined 28e. Place of it building.	njury - At home, farm, etc. (Specify)	street, factory,	office			28f. Location (a	Street and N	umber or F	Rural Route Number,		
9			(-),					Oily Or FOI	m, oldre)				
<u>e</u>	29a. Certifier 1 X Certi	fying Physician: To the bes	t of my knowledge, de	eath occurred a	t the tim	e, date ar	nd place,	and due to the	cause(s) and	d manner a	as stated.		
Medical Certification:	(Check only 2 Medi	cal Examiner: On the basis and manner s	of examination and/o- tated.	r investigation,	in my o	oinion, dea	ath occur	red at the time,	date and pla	ice, and du	ue to the cause(s)		
M	29b. Signature and title of cert	tifier		29c.	License	number			29d. Date signed (Month, Day, Year)				
	> WILL	No.	2		DO	35045				Inlv 20	9, 2008		
	30. Name and address of pers	son who completed cause of	death from 22a) /Tur	ne Print\	100		<u> </u>		•	,u1y 2	, 2000		
		d Henjum, M.D.,)rive	#200), Olr	nev. Mary	land 20	832			
	TALLEY OULLET					,	., ~-L	-,,					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day 2008 Year 23 William Fernandez 0518 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Min Months Days Hours 07/09/11/922 1 X M 2 □ F 86 087 12 6046 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 1 ☐ Yes 2 🕅 No Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3250 Bottner Road 20154 12. Was Decedent Ever in U.S. Armed Forces? 1942-1 Elyes 2 No 1966 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No Specify: Puerto Rican Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Flight Engineer US Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederico Fernandez Carolina Not Available 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria Nucci (daughter) 3250 Bottner Road/Gambrills MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 urial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemetery 8/20/08 4 ☐ Donation 5 ☐ Other (Specify) Arlington VA ^{22.} Name and Address of Facility Advent Funeral Services Falls Church VA & Annapolis MD 21. Signature of Fundral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2.24No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

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MD

Funeral

Director

show

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, It. Medical Exp., is a must be multiled a once.

Examiner burial-trar physician Physician/Medical the attending pl ed by the a detached f After this certificate has been signed by funeral director, page 2 should be detach 2 Completed Be Certification: To 24 hours after death. Funeral Director: A

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 9 Unknown

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

27. Manner of Death

1 ► Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2008

(Check only one) 29b. Signature and title of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

P56658

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAMC 2001

ABRAHA 31. Date filed (Month, Day, Year) 32. Regist 2 8 2008

Parkway ANNAPOLIE,

State Registrar

filled in by

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James Roland Farlow July 2008 9:00 AM 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 2/9/1920 88 213-18-5375 Director MD Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland not Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or of returnante event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 209 St. Louis Ave. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No þ Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James D. Farlow Winnie Mae Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilly M. Farlow / wife 209 St. Louis Ave., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 8/2/2008 Evergreen Cemetery Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signur of un 22. Name and Address of Facility ervice Licensee Burbage Funeral Home netala 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theosclee to 1. 1043 vercula **Physician** cus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 250 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, attending pl signed by the a To the Hospital or Attending Physician:

Farlow, James R. Baltimore, Maryland 21215-0036

after death.

I Director: After this certific d in by the funeral director, within 24 hours aft

To the Funeral Di

completely filled in

PA 8+1

ripholo, Barodulu State

29a. Certifier

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coestel Had

29c. License number

🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 31/18

Functi Febral, De 19944

32. Registrar's Signature 3 1 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Day 4:05 A Helen Barbara Fuller 26 06008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 407 West St. Berlin Worcester 3. Date of Birth (Month, Day, Year, 3/11/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Min. Months Days Hours 1 ☐ M 2 💢 F 093-18-9427 85 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Worcester Berlin 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 407 West St. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decest. Armed Forces? 1 ∏Yes 2 🛣 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications U S Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph John Raiman Julia Dorothy Dziedzina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl Ranger Fuller 106 Bryan Ave., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 7/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 21. Signature of Funeral Service Li 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Pan . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

requires that the death certificate be executed

The certificate

Hospital or Attending Physician:

this

within 24 hours after www...

To the Funeral Director: After the funeral py the f

Medical

State Registrar

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other

Baltimore, Maryland 21215-0036

Examine Physician/Medical Š

attending physician and for use as the burial-tran ed by the signed I Completed cate has by page 2 s director, Be Certification: To After th funeral

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

25. Was case referred to medical		
examiner? 1 ☐ Yes 2 ☐ Ho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outp
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tir Ini

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) patient 3 DOA me of 28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 1∐Yes 2⊅TÑo

Watural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

10 300 1733 SHUSBURYUD 21802

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number DO058410 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUMM WARLS COASTAL HOSPICE

31. Date filed (Month, Day, Year)

2008



DHMH 17 Rev 1/2001

BA 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Wilson Fils-Aime 3:42 p July 27, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 13℃M 2 1 F Director 267-99-9402 57 Jan. 25, 1951 Haiti Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Modical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6911 23rd Place 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Yes 2★ If Yes, Give Year or Dates: 1 Never Married 21 Married 1 ☐ Yes 2 ☑ No ģ Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 2 should be filed w h and Mental Hygiel is marked other th Cab Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oatson Fils-Aime Amelie Auguste ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur Icianie Fils-Aime/Wife 6911 23rd Place, Hyattsville, MD 20783 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State August 2 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCUFIANC DISEASE HEART /Medical Due to (or as a consequence, of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of) INSUFFICIENCY and Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical CONSECTIVE HEART IE FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 🗆 Unknown signed be peta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed' certificate 2 No 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Records, Division of Vital To the Hospital or Attending 4 hours after death.

-uneral Director: β
ely filled in by the fu filled in I within 24 hours af
to the Funeral D
completely filled ii

determined

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

be executed

Box 68760.

Maryland 21215-0036

Baltimore.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARROLL ALE. TAKOMA PARK, MO 20912 UR. IRVING WESTNEY 31. Date filed (Month, Day, Year) Registrar's Signature State 30 Registrar

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

70 48083

29d. Date signed (Month, Day, Year) July 28, 2008

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0205 **Physician** Larry Irvin Gibbons Auq 2008 /Medical 4c. County of Death Allegany 4a. Facility Name (If not institution, give streat and number)
Memorial Hospital 4b. City, Town, or Location of Death Examiner Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 F ĎΑ Oct 11, 1943 Director 293-38-5904 64 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MI Wayne Southgate Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 13258 Catalpa 48195 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify Specify. 2 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Self Employed Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Gibbons Ruth Bracken ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 13258 Catalpa 48195 Linda Gibbons Southgate MΙ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Michigan Services 8/12/2008 MI Livonia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between 2 Orset and Death Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Physician /Medical Coronary artery heart disease **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Diabetes burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy 1□ Yes 25. Was case referred to medical examiner?

Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ne Hospital or Attendl 24 hours after death. se Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

Snow, M.D. <u>Paul</u> 31. Date filed (Month, Day, Year) **AUG 13** 2008

29b. Signature and title of certifie

Dpty Med

and mapper stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D09157

29d. Date signed (Month, Day, Year)

Aug 8 2008

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month <u>11:1</u>5A [™] Elena Lynn Gould 25, 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 12202 Northbrook Drive Glenn Dale
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Davs Hours Months Director 220-75-4002 July 24,2006 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show Examiner must be notifled at Maryland Anne Arundel 1 ☐ Yes 2 1 No Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Hawthorne Street 20764 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Heafith and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any liuly or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be April Wrubleski Garv Gould 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Gould / Mother 1300 Hawthorne Street, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-29-2008 Davidsonville, MD 4 Donation 5 Dother (Specify) Lakemont Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VASCULITIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEIZURE DISORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit RESPIRATORY FAILURE Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 2 ☐ No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 QOther (Specify) Grandmother's Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

KIM, M.D 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401

MD

BRANDERMILL BLUD, #290, CROFTON, MD 21114

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:40 A M Gallagher August Charles Richard 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 X M 2 □ F Days 159-36-4116 May 18, 1944 Pennsylvania **Director** 64 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Newford Evander and the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2 TxNo Funeral Director MD Hagerstown Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21742 18646 Carolyn St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 VYes 2 2 No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Lawn Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert T. Gallagher Marian J. Kidner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Yarber/Daughter P.O.Box 285 Starke FL 32091 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 8/8/2008 Rest Haven Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final Physician monto disease or condition resulting in death) ar alhoma Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Little onderlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for o. 1 ☐ Yes 2 ☐ No 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) michael

State Registrar

DHMH 17 Rev 1/2001

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mack

82. Registrar's Signature

chael

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Day 2008 Year **Physician** JULY FELICIA **GANTT** 6:12 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8030 CHESTNUT AVENUE PRINCE GEORGE'S BOWIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 13 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Min 1 ☐ M 2 💢 F 218-54-9448 Yrs WASHINGTON, DC Director 57 1951 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Neutral Exemiter must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8030 CHESTNUT AVENUE USA 20715 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No BLACK Specify <u>۾</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th BUS AIDE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT CONTEE THOMPSON MARY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8030 CHESTNUT AVENUE BOWIE, MARYLAND 20715 MARVIN GANTT SR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. MD VETERANS CEMETERY 8/7/2008 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CANCER OF LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has Division of Vital 1 ☐ Yes 2**X** No 2 X No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Specify} \) 2 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5711 SARVIS AVENUE # 302 RIVERDALE, MARYLAND 20737 EDURADO FLORES M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JUL 3 1 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo

			1 - State of Maryland		tificate of i			Reg. No.	08 26081
	Physici		1. Decedent's Name (First, Middle, Last) Arndie Glover				2. Date of Dea Month July		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County	of Death
	Funeral		St. Thomas More Nursing & Rehamation St. Social Security Number 6. Sex 7. Age (In yrs. 1	last birthday)	Hyatts If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)
l,	Director		220-62-6016 1 1 2 M 2 □ F 55 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 10/25/1	952	Tar Heel, N.C.
	yland how	_	10a. State 10b. County 10c. City	y, Town or Loca	ation				10d. Inside City Limits
	he Mai	Director	Md. P.G.	Capito	l Height	.s			1 Mayes 2 □ No
	h with t	al Dir	10e. Street and Number 4605 Zion Street		10f. Zip Code 2074	3		10g. Citizen of V	J.S.A.
	er deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Wa		ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14 Rac	ce - American Indian, ck, White, etc. African—
036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Evan har mult be natified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1[□Yes 2. No	Specify:		Specify	Airican- American
21215-0036	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occup ind of work done of O NOT use retired	durina most of worki	ng	16b. Kind of Bu	usiness/Industry
212	d withii rgiene. er than	Somp	Elementary/Secondary (0-12) 1 College (1-4or 5+)		aborer	,		Cons	struction
Maryland	- 0 9	Be	17. Father's Name (First, Middle, Last) Chester Glover			18. Mother's Name Rosa Ma			ne)
ary	should and Me s mark umatic	P	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Rura			, State, Zip Code)
	and 2 lealth a m 27 is		Rosa Mae Glover/Mother			Capitol H			
mor E	Pages 1 ent of H nt: If ite ry or ot				tion (Name of atory or other place Ja† 1] Me				- City or Town, State L, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	22.	Name and Addre	ss of Facility ashington	& Sons	Co Inc	r.
	= @ O	1 0	23a. Part 1. Enter the disease, or complications that caused the death	432	23 BULLO	ugiis Ave.	, N.E., W	asningt	On, D.C. 20019 Approximate
. No.	Physician	8	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence)	uence of):					6/65/13
	P +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	uence of):					3
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R O X	certifica ding ph		IF FEMALE:						
200	death e atter d for u	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of december 25c.	Ideath 3□8	Ectopic pregnanc Other <i>(specify)</i>	У			ite of delivery onth Day Year
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ב	The la ate has bage 2	Completed	Hypertension				autops perfor	sy med?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
VItal	Physiclan: this certific ral director, p	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death	(Check only or	ne)	-
	Phy rat di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	3 LI DOA 28c. Injur	er: 4 Nursing Hory at	ne 5 🗌 Resid 28d. Describe h	ence 6 □Oth ow injury occurr	ner (Specify) red
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2	s after al Direct by ed in by	Certification:	4 ☐ Homicide determined building, etc. (Specify	nie, iaim, stree	a, lactory, office	(City or Tow	n, State)	ber or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my know 2	wledge, death o tion and/or inve	occurred at the tirestigation, in my o	me, date and place, pinion, death occurr	and due to the ded at the time, d	cause(s) and madate and place,	anner as stated. and due to the cause(s)
	To the compl	Me	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date signe	ed (Month, Day, Year)
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1	26		30 Name and address of person who completed cause of death (Item	1203	Qua	asbut	4 Pel	Hyallo	251 2008 DUILLAN 2014
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signal	The same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 30 7:00 p.m. Albert Green July Joseph 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's 48498 Mattapany Road Lexington Park If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Year) 1 X M 2 □ F 03/30/1929 218-24-3373 79 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland | St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 United States 48498 Mattapany Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Ŷes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Bus Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Ann Dorsey James Albert Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13200 Eddington Drive, Upper Marlboro, MD 20774 Joseph D. Green/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 08/11/2008 Cheltenham, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. Road, Leonardtown, MD 20650 22955 Hollywood Road, Leonardtown, MD Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each in e. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Due to (or as Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lo Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 S Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 🔯 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760, attending p use as detached for signed by t Division of Vital Records,

Physician

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Extramolation of the management of the Medical Extramolation.

Baltimore, Maryland 21215-0036

with the Maryland

within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant condition Completed by Be 25. Was case referred to medical examiner? 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

28d. Describe how injury occurred

1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

20636

se of death (Item 23a) (Type, Print) 30. Name and address of berson who completed cau

2008

24035 Jarboe. Three Notch Road, Hollywood, MD James P. M.D

31. Date filed (Month, Day. State

29a. Certifier

Registrar

within 24 hours a

To the Funeral C

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day \mathbf{A}^{M} Robert Styron Heise 2008 Ju1y 26. 9:01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Aug. 28 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 212-18-9521 Maryland Director 84 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director YYes 2□ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 660 Americana Drive Funeral Apt 24 21403 United States 12. Was Decedent Ever in U.S. Armed Forces? total Yes 2 □ No WWII HYes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Circuit Court marked other than Elementary/Secondary (0-12) College (1-4or 5+) Judge of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Heise Eloise Styron and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and 2 D partment of Health Important: If item 27 any Injury or other the Nadine S. Heise / Wife 660 Americana Drive Apt 24 Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory | 7/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PIVO HOVE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and signed by the attending physiclan and I be detached for use as the burial-transit Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy Pertension perform 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tiple of cer 29c. License number 29d. Date signed (Month, Day, Year) 0060221 July 26, 2008 Anne Arundel Medical Center 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMLETTE 2001 Medical Parkway Annapolis, Maryland 21401 MY State 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** Virginia **PEGGY** HOTCHKISS 08 08 /Medical 0815 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 8, 1925 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 83 Yrs. **Funeral** Days Hours 218-24-1301 1 □ M 250F Min Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Westernport MD. Allegany Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 21562 10g. Citizen of What Country death with 25801 Shady Lane, Apt. 220 United States Funeral Pages 1 and 2 should be filed within 72 hours after deal ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Evantherm. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. white 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Housework College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Kidwell John Bowers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Wilson/daughter 24601 Pocomoke Road, Westernport, Maryland 21562 20a. Method of Disposition Department of H Important: If iter any Injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 08/05/ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Mem. Park Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 152 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 011 disease or condition resulting in death) 2445 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) P.O. the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been si 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o e) Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 Yes 2 No 1 hpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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LOONAI

Elleng_o

Registrar's Signature

Seton

29c. License number

Drive, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26085 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CLARENCE WILLIAM 08 06 08 2000 /Medical HAT.T 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Months Min. Yrs. Director 69 **218-38-**0225 05-02-1939 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exacting rough be notified at Director 1 Yes 2 No MD ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 WEST MECHANIC STREET 21532 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1957 If Yes, Give Year or Dates: 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Completed by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 TRAINER TRUCK LOADER SHIPPING and Mental Hygin Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGIANN EDMONDSON HALL WILLIAM HALL ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 142 WEST MECHANIC STREET FROSTBURG, MD 21532 FMMA HALI SPOUSE other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of F int: If ite injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury of once. CUMBERLAND CREMATORY 8-8-2008 Cumberland, ,MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN ST., FROSTBURG, MBAL199ME, Sowers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BRE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner heur Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physiclan and for use as the burlal-tran certificate be execu Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 alcahal 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate perform 2 No 1 □ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records. Hospital or Attending in 24 hours after control of the Funeral Director: After the funeral in by the funeral of the function within 2.

Baltimore, Maryland 21215-0036

Box 68760

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State Registra

DHMH 17 Rev 1/2001

31. Date filed ANG 17 3 2008

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

STURNINA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / Dep. Registrar Ce	artment of Health and N <i>rtificate of Death</i>	ental Hygier Reg. 1	2000 2000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Mary Carol Hurry		August 6	pay Year 2008 12:30 p.m.
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			25397 Allston Lane	Hollywood		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	
	Director		229-84-0056 1□ M 2☒ F 52 Yrs.	WORKIS Days Hours Will.	11/26/195	5 Virginia
	pu ,		Usual Residence of Decedent			
	aryla shov	<u>_</u>	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director		Clements		
	ith th	ij	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evarriner must be notified at	rai	23925 Colton Point Road	20624		nited States
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 🔀 Married 1 □ Yes 2 🗂 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or i	by F	If Yes, Give	1 ☐Yes XX No Specify:		Specify: White
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	filed Hygi ther		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	Retail
Maryland	d be antal ced o	Be C	Kenneth Charlton Carter			•
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evarance must be notified at once.		20a. Method of Disposition 20b. Place of Disposition	Colton Point Road		S, Maryland 20624 Location - City or Town, State
altimore,	ages ant of t. If ii		1 M Burial 2 □ Cremation 3 □ Removal from State cemetery, cre	matory or other place)		
Ė	artme ortan injur		4 □ Donation 5 □ Other (Specify) Charles M. 21. Signature of uneral Service on see	emorial Gdns: 08/12	2/2008 Leo	nardtown, Maryland
Ba	permi Depa Impo any ir			2. Name and Address of Facility Bri		
			Edward N. Brinsfield, Jr. M00052 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not en			town, MD 20650-0279
E			shock, or heart failure. List only one cause on each line.	-	or respiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ver l'escase	Cirrhos	(s)
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×	eath certifi attending for use as	Š	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death atte	ciar	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	the c y the iched	Physician/M	1 ☐ Yes 2 ☑No 9 ☐ Unknown			
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Division of Vital Records,	Atten deal ctor: y the	Certification:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, str		28f. Location (Street	and Number or Rural Route Number.
<u> </u>	after Dire	erti	4 ☐ Homicide determined building, etc. (Specify)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	City or Town, St	
	spita		29a. Certiffer 1 Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place.	and due to the cause	e(s) and manner as stated.
	e Ho 124 h e Fui letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. Within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	0		· Annan	H00557	51	8160108
	100		30. Name and address of person who completed cause of death (Item 23a) (Type,			
	マス		Jennifer Schmidt, D.O., 40900 Merchant		Ma1	and 20650
F	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	b Laue, Leonardto	wn, maryla	4110 ZUOOU
	Registra	ar	AUG 0 5 2008	100		

DHMH 17 Rev 1/2001

			1 - State Registrar		,	Certificate of	Death		Reg. N	.2008	26087
п	Physic	an	1. Decedent's Name (First, Middle, Li	,				2. Date of D Month		^{ay} 2008 ^{Year}	3. Time of Death
Mr. S.	/Medi	cal	William Charles I 4a. Facility Name (If not institution, gi		r.	4h City Town	or Location of Death		_	c. County of Death	10:20 A M
أمر	Exami	ner	5626 Elberton Pla			Hyattsv			P	rince Geo	
	Funeral Director			Sex 7. Age 1∭ M 2□ F	(In yrs. last birtho	Months Dave		8. Date of Bi (Month, D Apr.	irth Pay Year L2,	1942 New	nplace (State or Foreign intry) Jersey
	yland	_	10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Ba-f s	Director	MD Prince (George's	Hyattsvi						1 □ Yes 2 No
	ath with the s 23a or 2	eral Dir	10e. Street and Number 5626 Elberton Pla			10f. Zip Code 20781			USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination to notified at once.	d by Funeral	11. Marital Status 1 Never Married	12. Was Decedent E Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1	0	13. Was Decedent of If Yes, specify Cul 1 □ Yes 2 No		pecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White, Specify: Whit	, etc.
15-("natu	lete	15. Decedent's E (Specify only highest g	ducation rade completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of work	king	16b.	Kind of Business/Ir	ndustry
212	withir jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	esman	<i>∌0)</i>		Bui	lding Pro	oducts
Maryland 2	uld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Las William Harrison	t)			18. Mother's Nam Elizabet		e, <i>Maid</i> e		
	and 2 sho lealth and m 27 is ma		19a. Informant's Name/Relationship William C. Harris		n 562	lailing Address (Stree	Place Hy	attsvil	lle,	MD 2078	1
Baltimore,	Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	ify)		isposition (Name of crematory or other pla ake Cremat	ory 07/3		Bel	Location - City or T tsville,	MD
Ball	permit Depar Impor any in		21. Signature of Funeral Service Lice	Hefrette	- MO1251	Going Hon Beverly I					ox 784 le, MD 2102
	Physician /Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. <u>Head and</u>	е.	ncer	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
**	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	consequence of):						
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с							
68760,	cate be ex ohysician the burial	Medical Ex	resulting in death) Last	Due to (or as a	consequence of):						
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ісу			23d. Date of deli- Month	very Day Year
ds, P.	uires that signed b d be deta	þ	Part II. Other significant conditions	contributing to death but	t not resulting in th	ne underlying cause g	iven in Part I.		tobacco		the cause of death?
of Vital Records,	ne law requir thas been s ge 2 should	Completed						24a. Was		24b. Were aut	topsy findings available ompletion of cause of
tal	ician: The certificate hi ector, page		25. Was case referred to medical	T			26. Place of Dea	1 □ Yes	347 N	lo 1 □Yes	2 🗆 No
Ϋ́	nysici nis cer direct	To Be	examiner? 1 ☐ Yes 2 ▓ No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpa	atient 3 DOA				6 ☐ Other (Spec	sify)
Division o	Attending Ph r death. ector: After th by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		y 28b. Tim (Ye <i>ar</i>) Inju	ry Wo	ury at ⊌rk?]Yes 2 □ No	28d. Describe	how inj	ury occurred	
Divi	ital or Att urs after d ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	building, etc.		, street, factory, office		City or To	own, Sta		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier 1	hysician: To the best of miner: On the basis of and manner stat	examination and/	teath occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the rred at the time	e cause e, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	With Common of the common of t	M	29b. Signature and title of certifier	ulloz	~	29c. Licer D2 374	se number			pate signed (Month y 28, 200	
	5+1		30. Name and address of person who Martin D. Weltz,				. Suite 2	.05 Gree		<u> </u>	
	Sta Regist		31. Date filed (Month, Day, Year)	2008 32. Registra	r's Signature	South					

		For State	State of	of Marylan		artment o					008	2608	8
		Registrar 1. Decedent's Name (First, Middle)	le, Last)	\	067	incate c	Deal	11	2. Date of Dea			3. Time of Death	
. Physici /Medio		Kathleer	1 D. +	torpe	2				JULY	26	2008	9:53 A	M
Examir	ier	4a. Facility Name (If not institutio				4b. City, Tow					nty of Death		
Funeral		5. Social Security Number	EDICAL CEN	7. Age (In yrs.	last birthday)	If Under 1 Ye	ANNAP ear If Und	OLIS der 24 Hrs.	8. Date of Birt	h	NE ARU	JNDEL place (State or Forei	ian
Director		455-22-1235	1 □ M 2 🗶 F	85	Yrs.	Months Da	ys Hour	rs Min.	(Month, Day	14, 192	Cou	EXAS	9.,
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limi	its
Mary I-f sho	tor	MARYLAND OU	EEN ANNE'	S		STEVI	ENSVII	J.E				1 □ Yes 2 🕱 N	
ith the	Director	10e. Street and Number			-	10f. Zip Cod				10g. Citizen o	of What Cou	ntry?	
sath w s 23a nust b			N ANNE CLI				2166				ITED S		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ▼ Widowed 4 □ Divorced	ried Armed Fo	2 ∑ No ive		was Decedent of If Yes, specify 0 1 ☐ Yes 2 2 1	Cuban, Mexi	ican, Puerto	cify Yes or No- Rican, etc.)	В	lace - Ameri lack, White, cify: WH	, etc.	
215-0036 thin 72 hours aff be. nan "natural", or Medical Exami	ted	15. Deceder	int's Education est grade completed)		16a. Deced	dent's Usual Oc	cupation			16b. Kind of	Business/Ir	ndustry	
ithin 7	Completed	Elementary/Secondary (0-12)	College (life. I	kind of work do DO NOT use re	tired)	nost of Workii	ng			_	
d 21 filled wi Hygien fiher th	S	12 17. Father's Name (First, Middle,	Last)			HOMEMAK		other's Name	(First, Middle,		N HOM	Œ	
lan Jid be fental rked o	To Be	FRANK DESKINS	,						A STEPI		umoj		
Maryland d 2 should be file th and Mental Hy 77 is marked othe traumatic event,		19a. Informant's Name/Relations			19b. Mailir	ng Address (Str	eet and Nur	mber or Rura	l Route Numbe	er, City or Tow	ın, State, Zi	p Code)	
e, N 1 and Health em 27 ther tr		WOODROW A. HA	ARPER/SON	20h F		QUEEN A			RIVE, ST			MD 21666	
nor ages ent of it: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (5		State	cemetery, crer	natory or other	place)	JUL	Y 28	20c. Location	-		m.
Baltimore, permit. Pages 1 a Department of Hee Important: If Item any injury or othe		21. Sign to Funeral Service		7	22	2. Name and Ad	dress of Fa	cility				L, MARYLAN L HOME, P 21619	
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the deat							LAND	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	A		atio	/		mer				Onset and Death	
/Medical Examiner		resulting in death)	Due to	(o as a conseq								10000	
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58760, icate be executed physician and s the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):								
	dical		d										
Box 6 death certiff teath certiff	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna						23d. I	Date of deliv	rerv	
IS, P.O. BOX res that the death cer igned by the attendin be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown		birth 2 ☐ Feta nant at time of d nown		JEctopic pregna] Other <i>(specif</i> y					Month	Day Year	
P.C		Part II. Other significant conditi			ulting in the ur	nderlying cause	niven in Pa	nrt I	23e Did to	nhacco use co	ontribute to	the cause of death?	
Records, he law requires the has been signed ge 2 should be d	d by		BSTruci		DUIM	on ary	· di	sease	1 U Y			10	٧n
Record le law require has been sig	Completed							,	24a. Was		b. Were aut	opsy findings availab	ole .
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OF Phys er this eral dii	7. To	1 ☐ Yes 25 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	T SOLDOA	Other: 4 njury at		ne 5 Resid			fy)	_
ion (inding F ath. r: After re funera	atior	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	ig .	nth, Day Year)	Injury	\	Vork? I∐Yes 2				unos		
Division or all or Attending Physical or Attending Physical or after death. In Director: After this of in by the funeral dispersed in the funeral dispersed or all	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place	e of injury - At ho ling, etc. <i>(Specit</i>	ome, farm, str	eet, factory, offi	ce	2	28f. Location (S City or Tow	Street and Nui n, State)	nber or Run	al Route Number,	
Division or Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier (Check only one) Certifying Certifying Certifying	ng Physician: To the Examiner: On the b and man	e best of my kno basis of examina oner stated.	owledge, death	n occurred at th vestigation, in n	e time, date ny opinion, d	and place, a death occurr	and due to the e	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)	
To the within To the complex c	Me	29b. Signature and title of certifie	" A NI	1		29c. Lio	ense numbe	ər		29d. Date sig	ned (Month,	Day, Year)	
hac		- Man	1 1/	en	ex M	D	00	245	7/	07/	28/	2008	
مهر		Paul B, Ber	who completed cause	2 2 2 :	25E	Defe	750	Huy,	Crot	cton,	mo	21114	
Sta Registr		31. Date filed (Month Day, Year)	9 2008 32.	egistrar's Signa	sture 4	and				7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Day Handfield July 28, 2008 7:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days 117 M 2 □ F Director 039-09-1592 82 Aug. 8, 1925 Rhode Island Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Director ir than "natural", or Items 23a or 28a-f s the Medical Evaminer must be notified 1 ☐ Yes 2 TNo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 3601 Saul Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 2 White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Corporate Law Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Joseph Handfield Anna McGinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese M. Handfield/Wife 3601 Saul Road, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State August 2 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory **2008** Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IMDN/ /Medical Due to (or as a consequence of): **Examiner** 5 quertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit EMEN Due to (or as a consequence of): Box 68760,)MA-712 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) of Vital Records, P.O. I 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No After this certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of D. ath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation safter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D55054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEDERICK KASI MD 604 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760 To the Hospital or Attenc within 24 hours after death To the Funeral Director:

> and address 31. Date filed (Month, Day, 32 Registrar's State 30 Registrar DHMH 17 Rev 1/2001

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(Check only one) 29b. Signature an



cause of death (Item 23a) (Type, Print)

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

50454

Arast∞ Yazdani, M.D.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2.0.0.8

			For State Registrar	State of M	arylan		artmen rtificat					iene 2	008	26091
			1. Decedent's Name (First, Middle,	Last)							Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Cha	rles Elwood H	amilto	n					July	29	2008	3:12 ^a M
	Examin		4a. Facility Name (If not institution,	give street and number,)		4b. City,	Town, or	Location	of Death		4c. Cou	nty of Death	
4.7			Montgomery Gener	al Hospital					Olney				Montgo	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	 Date of Birth (Month, Day, 	ate of Birth Aonth, Day, Year) 9. Birthplace (Sta		
	Director		212-20-2263	16 W 20 F	83	Yrs.					July 2,	1925		Maryland
	pur 💉		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						1	I0d. Inside City Limits
	aryla sho	٦ ا			100. 01.	y, 101111 OI 20	oation							1 □ Yes 2 🗷 No
	the Marylan 28a-f show	Director	Maryland Mo 10e. Street and Number	ntgomery			105 7:-		lver	pprin		On Citizon	of What Cour	otru?
	72 hours after death with the Maryland hatural", or Items 23a or 28a-f show disal Examinat must be motified at	ä					10f. Zip	code	0000		'	og. Citizeti		
	s 23	Funeral	1005 Orcha		- Francis III	0 40	Man Dane		2090		asifu Van ar Na	14.5	U.S.A	
	er de Item	Ş	11. Marital Status	12. Was Decedent Armed Forces 1 ▼Yes 2 □	?	5. 13.	If Yes, spe	cify Cuba	ın, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
36	", or	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □Yes	2 🗶 No	Specify:			Spe	cify:	T Rod & a
5-0036	hour tural	ed	15. Decedent		WWI	16a. Dece	dent's Usu	al Occup	ation			16b. Kind o	f Business/In	White dustry
215	in 72 "na Ledic	olet	(Specify only highest	grade completed)		(Give	kind of wo DO NOT u	rk done d	during mos	t of work	ing			,
212	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12) 10	College (1-4or	5+)		В	rick	Mason				Constr	uction
D	filed i Hygi other ent, ii	Be C	17. Father's Name (First, Middle, L	ast)					18. Moth	er's Name	e (First, Middle, I	Maiden Surr	name)	
lan	ld be lenta ked ked	To B	Ch	arles Elwood	Hamilto	on					Ella Eli	zabeth	King	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a -f show any higher or other traumatic event, the Medical Exemperation must be rediffied at once.		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailii	ng Address	(Street	and Numb	er or Rur	al Route Number	r, City or To	wn, State, Zip	o Code)
Ž	and 2 ealth a n 27 is		Henry L. Hamilton	- Son		15119	New I	lampsl	hire A	venue	, Silver S	Spring,	Maryla	nd 20905
ľe,	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Na	ne of	101	(Date	20c. Location	on - City or To	own, State
J.	Pages nent of int: If its iry or o		1 Burial 2 Cremation 4 Donation 5 Other (Sp		;	klawn Me				ns/n	1/2008	Rocky	ille, Ma	arvland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service t	~ / /	rai	22	2. Name ar	nd Addres	ss of Facili	tv			ille, ik	ii y i and
B	D-p d m g any		12 Klath	Horn	CES	SD !	lines-l	Rinalo	di Fun	eral	Home, Inc.	er Spr	ino Mai	ryland 20904
			23a. Part 1. Enter the disease, or o	complications that cause	ed the death		-						ing, im.	Approximate Interval Between
	Physician		shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	only one callse on each I	line. Do W	MINA	1 1	Aon	YA	73	from 8	3051		Interval Between Onset and Death
1	/Medical Examiner			Due to (or as	a consequ	uence of):								
	sate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequ	uence of):	UNI	DE	f Ora	i Fr	Foci)		
Ć,	execun an ial-tr	Exa	resulting in death) Last	Due to (or as	s a consequ	uence of):						/		
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68	iffica g ph as th	edi		1		1				0				
Вох	eath certific attending p for use as f	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75					23d.	Date of deliv	rery
0.B	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □Yes 2 ██No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			☐ Ectopic p ☐ Other <i>(s)</i>		у				Month	Day Year
σ.	that the ed by detac		Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying o	ause give	en in Part I		23e. Did tol	bacco use d	ontribute to t	the cause of death?
of Vital Records,	luires than n signed ld be det	d by									1 □ Ye	es 2∐N	o 3 Pro	bably 4 Unknown
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Re	: The law cate has page 2	m d									autops	sy med?	prior to co death?	ompletion of cause of
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S	Vttendl death. ctor; / y the fu	fica	3 ☐ Suicide 6 ☐ Could n	ot be 200 Place of In	niury - At ho	me, farm, str				-	28f. Location (Si	treet and Nu	ımber or Rur	ral Route Number,
Division	for A after Direct	Certification:	4 ☐ Homicide determin	building, e	tc. (Specif	y)		,,			City or Towi	n, State)		
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	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical		xaminer: On the basis and manner s	of examina									
	ompl	Me	29b. Signature and title of certifier		>		29	c. Licens	e number		2	29d. Date si	gned (Month,	Day, Year)
	()		n				1) p.i.	62	ر (3		02/2	2/08	2
	771	- 1	30. Name and address of person v	yho completed cause of	death (Item	23a) (Tune			BC			7112	-(1-0	
	,	ļ ļ	SATIO	1 = A/1				eet.	Hagers	town.	Maryland	21740		
	Sta	te	31. Date filed (Month, Day, Year)	20	rada Ciana	Aa	4	,	-0		,			
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Theodore	Hoover, III	
THEOLOGIC	1100 001, 111	

2008 26092

		I- For State Registrar		Certificate	of Death			Reg. No.	-	
Physicia		1. Decedent's Name (First, Middle, La	st)					e of Death		3. Time of Death
al Examir		The same the	SOUTA III				Mon	ith Day Just 6, 2008	Year	2020 hrs
ar Examin			DOVER 111							
		4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, o	r Location of D	eath		. County of Dea	
		8266 Bodkin Avenue			Pasadena			Ι Δ	Anne Arund	el
Euporal		5. Social Security Number 6. S	Sex 7 Age (In	yrs. last birthday) If Under 1 Yea	ar If Under 24	4Hrs. 8. Da	ate of Birth(MM/	DD/YYYYY 9. E	Birthplace (State or
Funeral		o. dodiai dedanty Nambe.	7.7.g0 (III	, 10. 100t Emanday	Months Day		Min	-	For	eign
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	F	Usual Residence of Decedent								
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21215-0036 and be filed within 7: Mental Hygiene, marked other than c event, the Me lical	2	19a. Informant's Name/Relationship ((Type, Print.)	19b. Ma	iling Address (Stre	et and Number	r or Rural Ro	oute Number. C	ity or Town. St.	ate, Zip Code)
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Baltimore, Maryland 21215-0036

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		For State Registrar		f Marylan	d / Depa		t of H	ealth a				0.0	n 8	260	194
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Funeral		5. Social Security Number 215–26–9718	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	Vro	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)		9. Birthplac Country,)	Foreign
Director		Usual Residence of Decedent			12					Feb. 1	2, 1	916	Maryla	and	
arylan show	7	10a. State 10b. County			y, Town or Lo								10d.	. Inside City 1 ☐ Yes	
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Page ment cant; If ant; If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	antsvi	lle C	emete	ery J		31, 20					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Europeal Service	Lipensee Pecon	ac)	I .					man Fu sville		_	mes, I 536	?.A.	
		23a. Part1. Enter the disease, or shock, or heart ailure. List	com lications that conly one cause on e	aused the deati		- 1		j, such as	cardiac o	or respiratory	arrest,		In	pproximate iterval Betw inset and D	veen
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as a consequ	Neo	plas								2 m	inth
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The law requires that the death certifica ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	tcome pf pregna pirth 2 □ Feta nant at time of d own	I death 3	⊒Ectopic pr ⊒ Other (sp						23d. Date Mon	e of delivery ith Da	ay Y	'ear
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the Examîner: On the b and man	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tim in my op	e, date ar pinion, dea	nd place, a	and due to the ed at the time	cause(s)	and mar I place, a	nner as state	e cause(s)	1
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Sta	3	30. Name and address of person Way we at 31. Date filed (Moor) Day, Pearl	aiserme	se of death (Item 130 legistrar's Signa	79 gas	Print)	iigh	eky	E	rakle	und	in	1 21	550)
Registr		V	2,000	1. 189.0 h	OF V	and p									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yvonne M. Johnson 2008 July 11:22A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 □ M 2 X F 212-34-0126 70 Director 1 1938 Maryland July: Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Evantines is ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Director Glen Burnie 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 654 Sprite Way 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) 12th Natural Resources Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ John A. Makell Sr Pocohantus Griffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Md. 21061 Camillia A. Johnson(Daughter) 654 Sprite Way Department of Health Important: If item 27 any Injury or other tronce. 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cornetery) ordered to their place. Date 1 🎇 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-28-08 Annapolis, Md. Memorial Park 4 Donation 5 Other (Specify) Am Name Rock Actions of Eacilia Ons Mortuary, P.A. 21. Signature of Funeral Service Licensee Keege M 00 483 821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Scleros1 > Amyutrudhic Lateral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown rcare nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Division of Vital 1 ☐Yes 2 ☑No 2 No After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Assistant 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 25,2008 rutes SU (C) Nev religy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greenest N4WS6 Bultimore, MDZ1201 Gerecke, MD Bunne 31. Date filed (Month, Day, Year) Registrar's Signature 2 8 2008 Registrar

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Registrar

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			1 _ State	Department of Health and N Certificate of Death		2000	26007
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Deat	th	3. Time of Death
	Physici /Medio		Joanna Kunciw		July 2	Day Year 2.5 2008	9:20 P ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	1
			Berlin Nursing Home	Berlin		Worcest	
- 12	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 176 – 28 – 4127 85	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	Year) 9. Birth	pplace (State or Foreign untry) Poland
	Director		Usual Residence of Decedent		9/13/19	922	Poland
	nyland how		10a. State 10b. County 10c. City, Town				10d. Inside City Limits
	e Ma Ba-f s	Director	MD Worcester Ber	in			1 ☐ Yes 2/☐ No
	with th	Dire	10e. Street and Number	10f. Zip Code	t	0g. Citizen of What Co	untry?
	eath v	Funeral	9715 Healthway Dr. 11. Marital Status 12. Was Decedent Ever in U.S.	21811	necify Ves or No-	USA 14. Race - Amer	ican Indian
10	fter d	Fun	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
036	ours a ral', o Exam	by	3 ¼ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: whi	te
21215-0036	72 ho 'natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/I	ndustry
121	within sne. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+)	hoto Processor		Film Compa	nv
d2	Hygie Hygie ther		17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, I		ily _
JoAnna Maryland	1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. em 27 is marked other than "natural", or Items 23a or 28a-f show wither traumatic event, the Meulreal Examiner must be notified at	To Be	Lucas Zub	Stephar	nie Homyl	·	
ary	shou and M s mar	-		Mailing Address (Street and Number or Rui			ip Code)
-	and 2 saith a n 27 is		Bohdan Kunciw / son 2	O Cottonwood Ct., Be	erlin, MD	21811	
or. or.	ges 1 t of Hi if Item or oth			y, crematory or other place)		20c. Location - City or	
unciw,	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) St. Ma		/2008	Elkins Pa	
Bac	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Me. The I Examiner must be notified at once.		21. Signal de off uneral Safvice Licensee			Funeral Hom	е
	201		23a. Part1. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line.	108 William St.,			Approximate
	Physician		Immediate Cause (Final	Cardovarelle De			Interval Between Onset and Death
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	Examiner		Sequentially list conditions b.				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):			
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9	tificate ig phy as the	ledic	V				
Box	leath certific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deli	,
	e dea the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown	5 ☐ Other (specify)		Month	Day Year
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tol	bacco use contribute to	the cause of death?
Records,	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	d by		and areas you are a second areas are a second are a second areas are		es 2 No 3 Pro	_
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> _	Physician: this certificaral director, p	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou		ome 5□Reside	ence 6 Other (Spec	cify)
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Division or	death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa	M 1 Yes 2 No	28f Location (St	treet and Number or Ru	ural Bouta Number
Οį<	after I Dire	Certification:	4 Homicide determined building, etc. (Specify)	in, sacet, reactly, office	City or Town	n, State)	iai noute Number,
	ospita hours ineral		29a. Certifier Physician: To the best of my knowledge	, death occurred at the time, date and place,	, and due to the c	ause(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examiner: On the basis of examination are and manner stated.		rred at the time, o	late and place, and due	to the cause(s)
	To To	2	29b. Signature and title of certifier	29c. License number	2	9d. Date/signed (Monti	h, Day, Year)
			30 Name and address of pages who completed are still the said	Tuno Print)		ما مد د ده	0
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ith Medical Eventue is ust be retified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regis

		For State of Ma State Registrar	aryland / Dep <i>Ce</i>	ertificate of D	ealth and M <i>eath</i>	lental Hygie Reg.		8 26098				
iar	ı	Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death 12:48							
ica	ı	Doris Teresa Knot	t	4h Cib. Town ord	continu of Dooth	August	5, 200	8 P™				
ne	r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of Dea					
		40845 Medley's Neck Road 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign				
1		577-44-4363 1□ M 2\\ F	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye January 22	1933 Mar	yland				
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	agation				10d. Inside City Limits				
	5							1 ☐ Yes 2 🛣 No				
	בב	Maryland St. Mary's	Leona	ardtown 10f. Zip Code		100	Citizen of What C					
2	5	40845 Medley's Neck Road		20650		109	USA					
	rulleral Director	11 Marital Status 12. Was Decedent E	Ever in U.S. 13.	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No-	14. Race - Am					
		Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ N	lo			Rican, etc.)	Black, Whit	e, etc.				
	מ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 No	Specify:		Specify: Wh	nite				
	pe completed by	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupat e kind of work done du	ion ring most of worki	ng 16t	o. Kind of Business	/Industry				
	d l	Elementary/Secondary (0-12) College (1-4or 5-	+)	DO NOT use retired) memaker		0:	wn Home					
3	3	17. Father's Name (First, Middle, Last)	110		8. Mother's Name	(First, Middle, Mai						
	0	Joseph Aloysius Angle			Mary Lil	llian Gra	ves					
	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	fing Address (Street ar				Zip Code)				
		James A. Knott, Sr. / Husband	40845	Medley's New	ck Road, Le	eonardtown,	Maryland 2	0650				
		20a. Method of Disposition 1	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other place,	Augus	pate 200	. Location - City or	Town, State				
		4 □ Donation 5 □ Other (Specify)	Charles Me	morial Garden	ıs 9.20	008 Le	eonardtown,	Maryland				
		21. Signature of Furieral Service Liberary 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.										
	_	o puralty farance		nd 20650	Approximate							
ı		23a. Paft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
ı	Immediate Cause (Final disease or condition resulting in death) a. And Stage Cardiac Disease Due to (or as a consequence of):											
ı		Due to (or as a	a consequence of):									
Į	<u>u</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):										
	Examilier	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a										
i	Ľ	resulting in death) Last Due to (or as a	a consequence of):									
	d											
		IF FEMALE: 23c. If yes, outcome	20d D-4	15								
	200	in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery Month Day Year					
	r i ysiciati i ivi	1 Yes 2 No 4 Fleghant at 9 Unknown										
2	<u>></u>	Part II. Other significant conditions contributing to death but	co use contribute t	o the cause of death?								
1	ב ב	end Stage renal disease 1 TYes 2 TONO 3										
13	completed by	diabetes				24a. Was an autopsy	as an 24b. Were autopsy finding					
	5					performed	formed? death?					
å	מ	25. Was case referred to medical examiner?				(Check only one)						
F	2	1 ☐ Yes 2 ☐ Mo Prospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of Injul	nt 2 ER/Outpatie		4 LI Nursing Ho	me 5 Residence 28d. Describe how		ecify)				
		1 Matural 5 Pending (Month, Day 2 Accident investigation	(, Year) Injury	Work?	es 2 No	zou. Describe now	injury occurred					
1	2	2 Addition 6 Could not be	ury - At home, farm, s					Rural Route Number,				
1	2	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)										
1000	medical ceruiicanonii 10	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or i	ath occurred at the time investigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)				
1	ME	29b. Signature and title of certifier	2	29c. License			Date signed (Mon					
		· m		HOO	5575	/	8/16	108				
		30. Name and address of person who completed cause of de			T00 _ 1.	M 1	1 2005					
ate		31. Date filed (Month, Day, Year) 37 Registra	erchants Lan ar's Signature	e, Suite 205,	Leonardto	wn, Marylar	10 ZUOOU					
tra		AUG 9 7 2008	UB A									
200	1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#26perMD 7-30-08, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death p KWAPIEN Month BERTH **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glade Valley Nursing Home Frederick Walkersville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 ☐ M 2 😿 F Yrs. Director March 2. 1915 Connecticut 042-20-1034 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evantment must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 □Yes 2 □ No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number 8502 Adventure Court 21793 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 █No SpecWhite Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ladislas Straub Anna Gwozdz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8502 Adventure Court, Walkersville, MD 21793
Place of Disposition (Name of Date 20c. Location - City or Town, State Jean A. Balbach/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 29 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 2008 Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W,. Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Lobe Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□No 1 ☐ Yes 2 ZNo 1 □Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 6 □ Could not be 3 Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

State Registrar nd address of

Year)

2008

30

Date filed (Month, Day,

Name a

Registrar
DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** 06 2008 1825 LINDEMAN BETTY JANE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND 8. Date of Birth (Month, Day, May 3, 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 □ M 2 😿 F 84 Pennsylvania 1924 Director 196-18-0808 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, The Medical Evention in using a second of the control of the contr 1 ☐ Yes 2 🙀 No Director Boynton PA Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15532 USA 108 Liberty St. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify 2 Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Textiles 8 Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Bowers Albert Hochard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Springs Rd., Grantsville, MD 21536 Penny Billmeyer/Daughter Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Cemetery Aug. 9, 2008 Salisbury, PA
22. Name and Address of Facility Newman Funeral Homes, P.A. Aug. 9, 2008 Salisbury, PA 21. Signature of Funeral Service Lice Curace P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** in knayy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 TIInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 □ No 3 Probably 4 🔟 Únknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

SATURNINA 31. Date filed (Month, Day, Year) AUG 8

04-7 32 Registrar's Signature

67

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

08-05988 David Berklev Llovd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26101

	Date of Death Month Day August 5, 2008 3. Time of Death 1225 hrs									
	, togett e, = e e e									
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death									
38549 Bet Lane Mechanicsville	St. Mary's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or									
Funeral Director 5. Social Security Number 228-88-7722 6. Sex 1 x M 2 F 48 Yrs. 1 months 1 months 1 months 1 months 1 months 24 months 1 months 24	September 23, Foreign District Of Country) Columbia									
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
Machanicsvil										
Maryland St. Mary's Mechanicsvil 10e. Street and Number 38549 Bet Lane 20659	10g. Citizen of What Country?									
38549 Bet Lane 20659 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	USA cify Yes or No- 14. Race - American Indian, Black,									
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R	Rican, etc.) White, etc.									
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Dates: 1 Dates:	Specify: White ork done 116b. Kind of Business/Industry									
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired during most of working life. DO NOT use retired to the property of the prope	ed)									
Solution and the state of the s	Construction									
Property of the property of th	(First, Middle, Maiden Surname)									
John Beech Cobb 2 John Beech Copb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or River) 2 John Beech Cobb 2 John Beech Cobb	Lee Earion ural Route Number, City or Town, State, Zip Code)									
Truck Driver 106. Street and Number 107. Zip Code 108. Street and Number 108. Street and Number 109. Zip Code 109. Street and Number 109. Zip Code 109. Zip C	Colton's Point, MD 20626 Date 20c. Location - City or Town, State									
Truck Driver 12 13. Mother's Name (15. Donn Beech Cobb 15. Truck Driver 16. Donn Beech Cobb 16. Donn Beech Cobb 17. Father's Name (First, Middle, Last) 18. Mother's Name (19. Donald Name of Cemetery, crematory or other place) 19. Donation 5 Other Specify: 20. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 21. Signature of Funeral Service Licespee 22. Name and Address of Facility Matting 192-Gardiner F 19. Donator Other Specify: 22. Name and Address of Facility Matting 192-Gardiner F 19. Donator Other Specify: 24. Donator Other Specify: 25. Name and Address of Facility Matting 192-Gardiner F 19. Donator Other Specify: 26. Donator Other Specify: 27. Name and Address of Facility Matting 192-Matting 192-M	Date 20c. Location - City or Town, State 1st 8, Alexandria, Virginia									
Augustia de la composition del composition de la composition de la composition de la composition del composition de la c	2008 Alexandria, Virginia									
21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee Authority Mattingley-Gardiner F P.O. Box 270 Leonard	Itown MD 20650									
'yysician 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arrest, shock, or heart Approximate Interval Between Onset and Death									
Immediate Cause (Final disease a. Intraoral Shotgun Wound	Deam									
Due to (or as a consequence of).										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course										
(Disease or injury that initiated events resulting in death) Last										
The property of the past 12 months? If FEMALE: 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 1 Live birth 2 Fetal death 2 F										
O a residual program of the program	23d. Date of delivery ancy Month Day Year									
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnate 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
Yes 2 No 9 Unknown g Unknown Yes 2 No 9 Unknown 9 Unknown Yes 2 No 9 Unknown 1 Unknown 1 Unknown 2 Unknown 3 Unknown 3 Unknown 4 Unknown 4 Unknown 4 Unknown 5 Unknown 5 Unknown 6 Unknown 6 Unknown 7 U	23e. Did tobacco use contribute to the cause of death?									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	1 Yes 2 No 3 Probably 4 Unknown									
Records, P The law requires in the law requir	24a. Was an autopsy findings available prior to completion of cause of									
te has the has a supplemental to the has a s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
26.Place of Death (Check examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing the control of th	only one) ng Home 5 Residence 6 V Other: Scene									
26. Place of Death (Check parties) 25. Was case referred to medical examiner? 1 Versit 1 Inpatient 2 ER/Outpatient 3 DOA Other; 1 Versit 2 No 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending FOWND: 1 Yes 2 No	28d. Describe how injury occurred									
O se ve	Subject shot self									
The standard of the standard o	28f. Location (Street and Number or Rural Route Number, City or Town, State) 38549 Bet Lane, Mechanichsville, MD									
determined (Specify) Residence 4 Homicide determined (Specify) Residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the control of	d due to the cause(s) and manner as stated.									
Aug 5, 2008 1225 hrs 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, date and place, and due to the cause(s)									
29c. License number	29d. Date signed (Month, Day, Year) August 6, 2008									
Patri Un-Polled in O.C.M.E.										
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201									
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margaret Arliene Lynn 10:45 a M July 26, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F Nov. 21, 579-62-7952 24 1923 Pennsylvania Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Justin Way 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Principal Archdiocese of Washington 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Sinclair Clark Edna Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary L. Moore/Daughter 701 Justin Way, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 2, Resurrection Cemetery 4 ☐ Donation 5 🖾 Other (Specify) Clinton, Maryland 2008 entambment Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Due to (or as a consequence of): Generalized Deconditioning Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last **Emphysema** Due to (or as a consequence of) Coronary Artery Disease IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown _ Alzheimer's 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **X**No 2 No 26. Place of Death (Check only one, Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No

Examiner certificate be executed and burial-tran Box 68760 attending physician the as use for P.0. the þ Records, pe has page certificate Division or Vital Attending Physician: this

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Baltimore, Maryland 21215-0036

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Certification:

Medical

State Registrar

/Medical

To the Hospital o within 24 hours aff To the Funeral D

25. Was case referred to medical examiner' 1 TYes 27. Manner of Death 1X Natural 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D20274 29d. Date signed (Month, Day, Year) July 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, MD 7710 Bradley Blvd., Bethesda, MD 20817

31. Date filed (Month, Day, Year)

3 0 2008



08-06048

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mental Hygiene

20 10	rease type of this in black in the
Patrick McKnight, III	State of Maryland / Department of Health and I

2008 26103

Johr	Patrick Mch		nt, III - For State	Sta	ate of Ma	aryland	/ Depai	rtment o tificate o	f Health f Death	n and	Menta	al Hyg		g. No.	20	08 26	5 1 0
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N	the Ma a or 23 tiffed	Eig	34 S.	Main S	t.					217					U.S.		
10	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status Never Marri	ied 2 M		as Deceder med Forces		.S. 13. W	as Deceder Yes, specify	nt of Hisp / Cuban,	anic Orig Mexican,	in? (Spec Puerto Ri	cify Yes or No ican, etc.)	- 14.	White, etc.	ican Indian, Black,	
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_	ysicia		Decedent's Name (First, Middle, Las EDWARD	^{t)} Jesse	MICH	AEL	2. Date o Month 08		Day Year 2008	3. Time of Death						
	dedica amine	_	4a. Facility Name (If not institution, give	,		4b. City, Town, or Location										
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show	Examiner m	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	WWZ	Nas Decedent of Hispanic C f Yes, specify Cuban, Mexic I □Yes 2 XM o <i>Speci</i> l		r No-)	14. Race - Amer Black, White, Specify: Wh	etc.						
21215-0036 d within 72 hours aft	the Medical	omplete	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) unknown	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired) Custodian	ost of working	1	Kind of Business/lichool Syst	•						
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Ball permit Depar Impor	any In		21. Signature of Funeral Service-Licen	e Sal		. Name and Address of Fac 11 Church St				21562						
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I Records, P.O. Box 6. The law requires that the death certificate has been signed by the attending p	88	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		1	23d. Date of deli	very Day Year						
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of Vita Physician: this certific	director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatier	Othor:	ce of Death (Check o		6 ∏Other (Spec	ify)						
ion ath. rr. Afte	he funeral	27. Manner of Death 1 Note in														
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	led in by t	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		on (Street r Town, Sta	and Number or Ru ate)	ral Route Number,						
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To th within To th	dwoo	Ž.	29b. Signature and title of certifier	Hadin		29c. License numbe			Date signed (Month							
		3	30. Name and address of person who o		th (Item 23a) (Type	D 26 40		m	icust 2,	2008						
	1	A	DR · HARTI+ Sic 31. Date filed (Month, Day, Year)	144 925	Bishop		1, Cumbe	elan	d.MDa	2502						

Registrar
DHMH 17 Rev 1/2001

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Oakland

	ylan now at		10a. State	10b. County		10c. City, 7	Town or Location				
	a-f sk	햦	MD Garrett Oakland								
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	h wit 23a o st be	교	16 N. S	econd Stre	et			215	50		Unit
	deat	ner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was D	ecedent of h	fispanic Origin? an. Mexican. Pu	(Specify Yes or lerto Rican, etc.)	No- 14
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If Item 271s marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Mar	ried 🌠 Married 4 🗆 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	No		es 21 No	Specify:	,	s
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9	filed Hygid Sther ent, tl	Be C	17. Father's Name	(First, Middle, Last)					18. Mother's N	lame (First, Midd	lle, Maiden Si
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ary	shousing N	-	19a. Informant's N	lame/Relationship (7	ype. Print)		19b. Mailing Add	iress (Street	and Number or	Rural Route Nur	nber, City or 1
Ž	1 and 2 Health a em 27 ls		Charles	H. McInti	ire, Husba	ınd	16 N.	Seco	nd Stree	et, Oakl	and, M
Baltimore, Maryland 21215-0036	Pages 1 an of He int: If Item			Cremation 3 🗆		1	ce of Disposition netery, crematory		1	Date	20c. Loca
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	Phonlelon	l ii	shock, or he Immediate Cause								
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		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Connective tissue disorder, unspecifie to be consequence of as a consequence of a c								
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ŏ	th cer endir r use	N/W	IF FEMALE: 23b. Was deceder		23c. If yes, outcome 1□Live birth	pf pregnand	cy leath 3⊟Ecto	pic pregnanc	:v		23
Э.	ed fo	sicia	in the past 12	X No	4□Pregnant at 9□Unknown			er (specify) _			-
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ū	Attending Physician: r death. ector. After this certifics by the funeral director, p	ü	27. Manner of Dea 1 X Natural	5 Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inju		28d. Descril	be how injury
Sio	or Attendi er death. irector A	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be		411	N]Yes 2 □ No		(0)
Division or V	er d	E E	4 ☐ Homicide		Zoe. Flace of fig	ury - At nom tc. <i>(Specify)</i>	ne, farm, street, fa	actory, office		28f. Locatio City or	n (Street and Town, State)
		Medical Certification:	20a Cartifian	1FF Cortifuing Dh	ysician: To the best	of my knowl	ledge death coo	irred at the t	ime date and al	lace, and due to	the cause(s) s
	To the Hospital within 24 hours a To the Funeral I completely filled	lica	29a. Certifier (Check only one)	2 Medical Exam	niner: On the basis o and manner st	of examination	on and/or investig	ation, in my	opinion, death o	occurred at the tir	ne, date and p
	o the ithin i	Mec		d title of certifier	1			29c. Licen	se number		29d. Date
	Z × Z	_	1 Pa	rala /	than			D30	0035		08-
				7 190	VUIVE	\					

McIntire

79

7. Age (In vrs. last birthday)

Yrs.

State Registrar

Barbara

5. Social Security Number

215-52-8430

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

16 N. Second Street

Ann

6. Sex

1 □ M 2 😾 F

4a. Facility Name (If not institution, give street and number)

er, City or Town, State, Zip Code) nd, MD 21550 20c. Location - City or Town, State Cumberland, MD 1 Home, P.A. nd, MD 21550 Approximate Interval Between Onset and Death months fied months 23d. Date of delivery tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No an psy ormed? 2 X No idence 6 ☐Other (Specify) how injury occurred (Street and Number or Rural Route Number, own, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 08-04-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R.Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 32 Registrar's Signature **ORIGINAL**

2. Date of Death

8. Date of Birth (Month, Day, Year)
June 2, 1929

August

Day

2008

Garrett

Ohio

14. Race - American Indian, Black, White, etc.

White

4c. County of Death

10g. Citizen of What Country? United States

Specify:

16b. Kind of Business/Industry

Own Home Maiden Surname)

4,

26/05

7:05 A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits M∑Yes 2 No

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 6 2008

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year John Merle Malotte August 2008 5:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Lutheran Health Care Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 219-05-2834 Yrs. Director 100 6, 1908 Mar. Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be matthed at Director 1. Yes 2 □ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 St. Mark Way Apt. 412 21158 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) executive printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel W. Malotte ၉ Birdie Iona Ream 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once. Jean M. Malotte/ daughter 21650 Keeney Rd. Freeland, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛮 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) A11 County Cremation 8/7/2008 Sykesville, MD 21. Si tu of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home athanie 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) 4 days /Medical Due to (or as a consequence of): Examiner CAD/ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 7 years Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig page 2 should b Dysphagia, advanced osteoarthritis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2× No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination anglor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei Medical he basis of exa (Check only one) within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37949 August 6, 2008 30. Name and address of person who completed cause of de (Item 23a) (Type, Print) Alexander Bogdaschewskyi Locust Lane, Suite 201 Westminster, MD 21157 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registra

Fil

				State of Ivia	il ylanu /	Certific		Death	_	Reg. No.			
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month		3. Time of Death		
J.	Physici /Medic	al	Bertha E. Willer 08 0								2 gm		
1	Examir	ner	^{4e} Feçility Name (If not institution, given Glades Valley Rehabilitati	street end number) Nursing on Cente	and			4b. City, Town, or Walkers		freder:			
	Funeral Director		5. Social Security Number 6. S 215-68-0396		e (In yrs. lest		Inder 1 Year oths Days			9. B 1917 Ma	Birthplace (State or Foreign Country) LTYLand		
	and w		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location MD Frederick Jefferson										
	Meryl Fesh	to	MD Frederi		1 ☐ Yes 2								
	th the	Director	10e. Street end Number		10g. Citizen of What Country? U.S.A.								
	23a c		4244 Horine	Road									
21215-0020	n 72 hours efter death with the Meryland "natural", or flems 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Merital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Decedent of I specify Cub es 2 X No	Hispanic Origin? (Sean, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	Black, W	merican Indian, hite, etc. White		
2-0	72 ho	et ed	15. Decedent's Ed (Specify only highest gra	ucetion de completed)	16	6a. Decedent's (Give kind o	of work done	during most of wo	rking	16b. Kind of Busines	6b. Kind of Business/Industry		
121	within ene.	Completed by	Elsmentary/Secondary (0-12)	College (1-4or 5	+)	life. DO No	OT use retire	nd)		Own Ho	me		
d 2	e filed within al Hygiene. I other than "	ပ္	8 Homemaker 17. Father's Name (First, Middle, Lest) 18. Mother's Nan							, Maiden Sumame)	ite		
an	id be ental ked o	To Be	Harry Blanch		hart	, Sr.		Emma	Alvert	a Woods			
Maryland	should and Men marke	-	19a. Informant's Name/Relationship (9b. Mailing Add				er, City or Town, State			
	end 2 salth a n 27 is	J	Samuel E. Mill	er, Son						son, MD			
Baltimore,	permit. Pages 1 end 2 should be flied within 72 hours el Department of Health and Mental Higiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exampne.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disposition (Name of cemetery, crematory or other place) Middletown Cemetery				Aug. 12, 2008 Freeland, MD				
Balt	permit. Departr imports any Inj.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24. Second St., New Freedom, PA 17349										
			23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
The state of the s	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Coroway artery disease year										
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	ifficete be executed g physicien end es the burial-trensit	Examiner	Sequentially list conditions,	b	Due to (or as	a consequence	9 of):				1		
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68760,	ificete be executed g physicien end es the burial-trensit	edicai	resulting in death) Last Due to (or as a consequence of):										
Box		N/C		d									
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of Vital Records,	sw requir s been s 2 should	Completed by	paraxysmal	atrial	Fibr	illati	ian			s an autopsy 24 ormed?	b. Were autopsy findings available prior to completion of cause of death?		
<u>ح</u>	E age	Con							10	Yes 2 XIII	1 ☐ Yes 2 ☐ No		
Vita	ysician: The	Be	25. Was case referred to medical examiner?	Hospital:			Ot		ath (Check only				
on of	φ w 5	ion: To	1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Dey	nt 2 ER/ ry Yea <i>r)</i> 281	Outpatient 3L b. Time of Injury M	28c. Inju	AMED NUTSING I		idence 6 □Other (S how injury occurred	pecify)		
Division	i or Attending I efter death. Director: After 3 in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ary - At home c. (Specify)					(Street and Number or Rural Route Number, own, State)			
	To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best on niner: On the basis of and manner sta	examination	dge, death occu and/or investig	urred at the t ation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner , date and place, and	r as stated. due to the cause(s)		
	To the Vithir To the	Me	29b. Signature and title of certifier	1.			_	se number		29d. Date signed (M			
			Val /	Heur	M			2019			7-2008		
			30. Name and eddress of person who	completed cause of de	23	(Type, Print)	rey	Ave =	reder	ickuld			
* 1	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Small 5							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Phillip 12:15P^M Miles August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis La Plata Center La Plata Charles If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Months 577-38-8033 80 Yrs. Director Sep.8,1927 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1X Yes 2 □ No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Number 1 Magnolia Drive 20646 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2☐No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumatic Laundry Routeman Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Miles Annie Hyde 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9258 Windsor Dr., La Plata, MD 20646

ce of Disposition (Name of Date 20c. Location - City or Town, State Ann E. Miles / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Cem. 11,2008 Brentwood, MD 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service Licensee 5635 Washington Ave., La Plata, MD20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Papumonia **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Years Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign be (ardiony pathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PRIEMAKEL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 1 No 2 🗆 No funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 6th, 2008 DOO61614 R. Sindhuml R. SINDHWANI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POST OFFICE ROAD, WALDORF 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30 am 2008 29 Isabelle E. McMahon /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 7900 Avis Mill Road Williamsport If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Yea. **Funeral** Days New York 1 □ M 2 🗓 F 77 June 1931 Director 080-26-9493 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

1s marked other than "natural" or items 23a or 20ad show 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21795 USA 7900 Avis Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married 1 □ Yes 2 X No Specify: Specify. White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McAndrews Raymond Eugene Ellis Kathryn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant; If item 27 Is I Williamsport, Maryland 21795 William B. McMahon - Husband 7900 Avis Mill Road item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X remation 3 ☐Removal from State Smithsburg Crematory 07-30-2008 Smithsburg, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funer J.F. Williamsport, MD 21795 425 S.Conococheague St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cardio voscular descase Alteroscleration **Physician** mins /Medical Due to (or as a consequence of) **Examiner** 54-ears ementie if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and burial-trar Due to (or as a consequence of) physician the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2 No 26. Place of Death (Check only one) Be

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate Physician; funeral director, After this or Attending death. within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

27. Manner of Death

29a. Certifier

(Check only one)

Certification: To

filled in by

completely

Hospital

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

1 Natural 5 Pending investigation 2 Accident

6 ☐ Could not be determined 3 Suicide 4 Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 A Residence 6 Other (Specify)

and manner stated. 29b. Signature and title of certifier Member

29c. License number

29d. Date signed (Month, Day, Year)

Holgestonne 44 D 21740.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19ANZAN AG 368

31. Date filed (Month, Day, Year) JUL 3 0 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Thomas Aubrey Kemp 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 212-38-9212 Director 97 19,1911 Maryland July Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Modifical Examinations to contract the modifical examinations. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Washington County 1 ☐ Yes 2 X No Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 13218 Briarcliff Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 X No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Self Employed Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh L. Kemp Mettie P. Kemp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Kemp-wife 13218 Briarcliff Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 7-31-2008 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eighting. pproximate iterval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-trar to or as a consequence of). P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s Was a autopsy performed? certificate 1 ☐Yes 2 ☐No 1 Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 201No 1 Yes **1** Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) Type, Print) 3H-25

DHMH 17 Rev 1/2001

State

Registrar

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2008

Date filed (Month

ORIGINAL

26111

		1	For State	Sta	ate of Ma	aryland	l / Depa <i>Cer</i>	artmen <i>rtificate</i>	t of H e <i>of L</i>	ealth a D <i>eath</i>	and Me		gien é- Reg. No.	000	201	
			Registrar 1. Decedent's Name (First, Middle,	i ast)							2	. Date of De			3. Time of D	eath
	Physicia		Agnes Regina MC									Month July	29 Day	Year 2008	1740	М
	/Medic		4a. Facility Name (If not institution,		and number)			4b. City,	Town, or	Location of		041)		County of Dea	ith	
	Examin	er i						ш	anar	stown	,		W	ashing	ton	
-			20435 Jefferson 5. Social Security Number 6	n Bou	11evard 7. Ag	e (In yrs. la	ast birthday)	If Under	1 Year	If Under Hours	24 Hrs. 8 Min.	Date of Bi		9. Bi	rthplace (State or ountry)	Foreign
	Funeral Director		202-03-5454	1 🗆 M	2 X] F	89	Yrs.	Months	Days	Houis	C	ct. 2	1,191		w Jersey	•
			Usual Residence of Decedent												10d. Inside City	Limits
	yland		10a. State 10b. County			10c. City	, Town or Lo	cation							1 □ Yes	
	e Mai	Director	Maryland Washi	ngtor	ı		Hage	rstow					10a Citi:	en of What C	country?	
	or 28	Dire	10e. Street and Number					10f. Zip	Code				rog. Otta			
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Exacting must be inclifted at		20435 Jefferso	n Bou	ılevard				217		iain? (Snac	ify Vas or N	0.	USA 4 Bace - Am	nerican Indian,	
	ems	Funeral	11. Marital Status	A	Vas Decedent rmed Forces?	•	5. 13.	If Yes, spe	cify Cuba	n, Mexical	n, Puerto Ri	ify Yes or Nican, etc.)		Black, Wh		
36	or it	by Fi	1 Never Married 2 Marrie	l If	☐Yes 2X Yes, Give	No		1 □Yes	2 ▼ No	Specify:	:			Specify:	White	
21215-0036	ural"	g p	3 ☑ Widowed 4 ☐ Divorced		ear or Dates:	_	16a. Dece	dent's Usu	al Occup	ation			16b. Kir	nd of Busines	s/Industry	
5	"nat	ete	15. Decedent's (Specify only highest	grade cor	npleted)		/Give	kind of wo DO NOT u	rk done i	during mos	st of working	7				
12	withir ene.	Completed	Elementary/Secondary (0-12)	\ °	College (1-4or:	5+)		Homem	aker				He	r own	home	
d 2	Hygi Hygi ther		17. Father's Name (First, Middle, L.	ast)						18. Moth	er's Name (First, Middle	e, Maiden	Surname)		
an	d be familiar	o Be	Julius Lang						ĺ			Carro				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exacting rust be natified at once.	은	19a. Informant's Name/Relationshi	ip (Type. F	Print)									r Town, State	, Zip Code)	
Ma	id 2 s ith ar 27 is 27 is		Ellen Moran Good			hter	159	Bond	St.	, New	Free	dom, 1				
o,	1 an Hea tem 2	1	20a. Method of Disposition			20b. P	lace of Dispe	osition (Na	me of other plac	ce)	Da	ite	20c. Lo	cation - City	or Town, State	
Baltimore,	ages ent of t: If if		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		val from State	Hag	ersto	wn Cr	emat	ory 7	7/30/0	8	Hage	rstown	, Maryla	nd
Ħ	artme ortan Injur		21. Signature of Funeral Service J.					2. Name a					Fune	eral Ho	ome	
Ba	permit. P Departme Importan any Injur		Cratt	M	22/11/2	111	4	15 E.	Wil	son 1	Blvd.	Hager	stown	n, Md.	21740	
			23a. Enter the disease, or o	come lication	on that cause	ed the deati									Approximate Interval Bet	ween
			shock, or heart failure. List of Immediate Cause (Final	only one ca			of th								Onset and I	007
	Physician /Medical		disease or condition resulting in death)	a	Due to (or a			16 00							10.00	
9	Examiner				Dao 10 (01 a											
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Due to (or a	s a conseq	uence of):									
	uted J insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	١.												
	cate be executed physician and the burial-transit	Exa	resulting in death) Last	· · _	Due to (or a	s a conseq	uence of):									
8760,	e be sicial	dical		Ld.												
89	ificat g phy is the	edic		1												
Box	eath certific attending p for use as	2	IF FEMALE: 23b, Was decedent pregnant		If yes, outcom			☐ Ectopic	pregnan	cv				23d. Date of Month		Year
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No		4 Pregnant	at time of		Other (.	William		
P.O.	at the de by the tached	hys	9 ☐ Unknown] an . n:	444444	uaa oontribut	e to the cause of	teath?
	ires that signed	Completed by Physician/Me	Part II. Other significant condition	ns contrib	uting to death	but not res	ulting in the	underlying	cause gi	ven in Par	t 1.					Unknown
ğ	quire; en sig uld bi	P P	Adult onse	Di	abete	s /VI	ellil	us				11	Yes 2			
၀	w requir s been s should	ete	Coronary ar	tery	disea.	50						24a. W	topsv	24b. Were prior	autopsy findings to completion of c	available cause of
Re	he law e has	E E			1.							pe 1 □ Ye:	normed?	deat	n? Yes 2∐No	
ta	ifficat or, pë		25. Was case referred to medical	not 1	diseas	62				26. Pla	ice of Death	(Check on	ly one)			
5	/sicia	o Be	examiner? 1 ☐ Yes 2 ▼ No	Hos	pital: 1 ☐ Inpa	itient 2] ER/Outpati	ent 3 □ l	DOA O	her: 4 🗆	Nursing Ho	me 5 R	esidence	6 ☐ Other (Specify)	
of	a Phy er this eral o	Ě	27. Manner of Death		28a. Date of Ir	njury D <i>ay, Year)</i>	28b. Time Injury		28c. Inj	ury at ork?		28d. Describ	e how inju	ry occurred		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig		(Moriti), 2	say, rour,	, ,,,,,	М	1[∐Yes 2[
isi	If or Attendiater death. Director: /	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		28e. Place of I	Injury - At h	ome, farm, s	street, facto	ory, office			28f. Location City or	n <i>(Str</i> eet a Town, Stai	<i>nd Numb</i> er o 'e)	r Rural Route Nur	nber,
ă	afte afte Dire	ert														
	spita nours nera y fille		29a. Certifier 1 Certifyir	g Physic	ian: To the be	st of my kn	owledge, de	ath occurr	ed at the	time, date	and place, death occur	and due to red at the tir	the cause(ne, date al	s) and manne nd place, and	er as stated. due to the cause(s)
	n 24 le Fu	Medical	(Check only 2 Medical one)	Examine	and manner	stated.										
	To the Hospital within 24 hours a To the Funeral Completely filled	Ž	29b. Signature and title of certifie	1				2	29c. Lice	nse numbe	er 		290. D	1.2 mlm m	fonth, Day, Year)	
			Radu M.	Vhe	doru	MD			1) 0	0455	63		01	SULLOU	O	
	-		30. Name and address of person	who comp	oleted cause o	of death (Ite	m 23a) (Typ	e, Print)	74	4	. /	4		0 1	21740	
0	N-5		Radu M. Theodos	4 M.	0 324	East,	Antiel	am S	Livee	26, 1	Hager:	slown,	Mar	ykand	21/40	
	S	tate	31. Date filed (Month, Day, Year)	4 000	32. Reg	strar's Sigr	nature									

			For	State of Marylan							-	
			1 - For State Registrar	13.17.411		rtificat					No.2008	26112
	Physic	an	1. Decedent's Name (First, Middle, Last)					2.	Date of Death	Day Year	3. Time of Death
	/Medi		Forchen Miller,			_				July 28	2008	3:40 a.M
	Examir	ner	4a. Facility Name (If not institution, give	,		,		Location of			4c. County of Dea	
	Funeral		505 Suffolk Aven 5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under	1 Year	Heigh	4 Hrs. 8.	Date of Birth	Prince G	thplace (State or Foreign ountry)
ŀ	Director		2/0 30 0099	¹ M 2□ F 78	Yrs.	Months	Days	Hours	Min.	(Month, Day, Ye	, 1930 Wa	shington,DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryla f sho ied at	for	MD Prince G				+-					対才 Yes 2□No
	r 28a-	Director	10e. Street and Number	eorges Ca	pital	10f. Zip				10g.	Citizen of What C	ountry?
	th wit 23a o 1st be	al D	505 Suffolk Avenu	e, #208		2	0743			Ţ	Jnited St	ates
	er dea tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced	lent of Hi cify Cuba	spanic Origii n, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whi	
36	J within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1		1 □ Yes	2 No	Specify:			Specify: B1	ack
Maryland 21215-0036	2 hou atura cal Ex	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usua	al Occupa	ation		166	. Kind of Business	/Industry
215	within 7, iene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired,	luring most o)	of working			
21	e filed wi al Hygien other th		12th		Feder	al Pr	otec	tion (overnment_
and	0 = 0 %	Be	17. Father's Name (First, Middle, Last) Forchen Miller,	Cr.					sName <i>(F.</i> ie Ha:	irst, Middle, Maid	den Surname)	
Ž	should be nd Menta marked matic ev	은	19a. Informant's Name/Relationship (Ti		19h Mailir	na Address	(Street a				ty or Town, State,	Zin Coda)
	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce.		Yvonne Miller	Wife								MD 20743
Baltimore,	of Hear		20a. Method of Disposition	20b. P	lace of Dispo emetery, crei	sition (Nan	ne of ther place	e) !	Date	200	. Location - City or	Town, State
<u><u>E</u></u>	Page ment ant: If ury oi		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		verda1	e Cre	mato	ry 08			rerdale,	
3alt	permit. Departi		21. Signature of Funeral Service Licens	ee Au								al Home, LLC
		1. 12	Janue Ve	morning !		_					gton, DC	20017
	_	3 g	23a. Park. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	i. Do not ent	er the mod	e or ayıng	g, such as ca	ardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. RADIATION CO Due to (or as a consequence)		WITH	ABCE	SS/FI	STULA			1 year
	Examiner			PROSTATE CAN	,							l 15 years
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ								,
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D								
760,	ate be executed nysician and he burial-transit	cal E		Due to (or as a consequ	ience oi):							
687	w requires that the death certificate been signed by the attending phys should be detached for use as the			d								
Вох	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna		-					23d. Date of de	livery
Ö.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pr Other <i>(sp</i>					Month	Day Year
P.0.	The law requires that the te has been signed by the hage 2 should be detached	Phys	9 □ Unknown	9LJUnknown								
	ires th signed	by i	Part II. Other significant conditions con HISTORY DIABETES 1	-	-	, ,	ause give	n in Part I.		23e. Did tobace	. /	o the cause of death?
Ö	requi	Completed by			OAIN	<u> </u>			- 4			robably 4 Unknown
Records,		фш	RENAL CELL CARCIN	INOMA					-	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Vital			25. Was case referred to medical					00 80		performed 1 Yes 2 1	No 1 ☐ Yes	2 □ No
	Physician: The Is this certificate har ral director, page 2	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DO	A Othe	· ·		heck only one)	e 6 □Other (Spe	ngifu)
0 C	ng Phr ter thi		27. Man or of Death 1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of		8c. Injury Work	at		. Describe how i		-cony)
Sior	Attending r death. ector: After by the funer	atio	2 Accident investigation	(Monar, Day Year)	пдагу	М		: ′es 2∐No	0			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory	, office		28f.	Location (Street City or Town, S		ural Route Number,
	pital		29a. Certifier 1 ☐ Certifying Phys	sician: To the hest of my know	uladna daatl	occurred	at the tim	o data and	place and	I due to the cour	a(a) and manner	t-t-d
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one)	sician: To the best of my knowner: On the basis of examinal and manner stated.	tion and/or in	vestigation	, in m y op	ie, date and pinion, death	n occurred	at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			290	. License	number		29d.	Date signed (Mon	th, Day, Year)
			Sact il S	umu	MO	МТ)1233	31		07	/29/2008	
2	(4)		30. Name and address of person who co			Print)					, 25/2000	
		4	Jack Summers			NW W	ashi	ngton,	,DC			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	are .							

		For State Registrar		State	of Maryla	nd / Depa	artment o			and Me	ntal Hy	giene Reg. No.	0000	20	110
. Physic		Decedent's Name (First Genevieve		,							. Date of De Month July	eath	2008 5, 2008	3. Time of 10:45	of Death
Exam		4a. Facility Name (If not in Southern Ma	ryland		•			into		of Death		4c.	County of Death		3
Funera Directo	_	5. Social Security Number 579–50–522 Usual Residence of December 1	6 1	x □ M 2	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	Date of Bir (Month, Da 1/29/	ay, Year)	Cou	place <i>(State</i> ntry) arolin	_
Maryland I-f show fied at	tor		County P.G.			City, Town or Lo								10d. Inside (City Limits
death with the Maryland ms 23a or 28a-f show r.must be notified at	al Director	10e. Street and Number 3407 23rd	d Park	way			10f. Zip Co	ode 2074	18			10g. Citi:	zen of What Cou	•	
ours after death with the Mar ral", or items 23a or 28a-f sh Examiner must be notified	by Funeral	11. Marital Status 1 □ Never Married 2 3 🕱 Widowed 4 □ D		Armed F	2 XNo ive		Was Deceden If Yes, specify 1 ☐ Yes 2 ፟፟፟X		spanic Ori n, Mexicar Specify:	gin? (Speci: i, Puerto Ri	fy Yes or No can, etc.))-	14. Race - Ameri Black, White, Af:	can Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examinen	Completed	15. D (Specify only Elementary/Secondary 12th	ecedent's Edu y highest grad (0-12)	le completed,	(1-4or 5+)	16a. Deced (Give life. L	dent's Usual C kind of work o DO NOT use i	Occupa done d retired)	ation luring mos)	t of working			nd of Business/Ir S. Posta	·	vice
ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, I	-							r's Name (/ ry Bit	First, Middle tting	, Maiden	Surname)		
and 2 sho ealth and m 27 is ma		19a. Informant's Name/Re Crystal D.	Gardne			3144	Jeffre	y R	Road,	Windso	or Mil	l,Ma	r Town, State, Zi ryland 2	21244	
Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 XI Cren 4 ☐ Donation 5 ☐ C	nation 3 F other (Specify)		i State	Place of Dispo cemetery, crer esapeak	e Crem	ato	ry, I				cation - City or T Beltsvi		đ.
Depart Impor any in	5	21. Signature of Funeral S	1 1/	ر کی ا	ray	4		rro	ughs	Ave.,	N.E.,	Washi	,Inc. ington,D	.C.200)19
Physician /Medical Examiner	ıf	23a. Part1. Enter the dishock, or heart failur Immediate Cause (Final disease or condition resulting in death)	e. List only o	ne cause on a.	each line.	JUNG	er the mode o			cardiac or r	respiratory a	ırrest,		Approxima Interval Be Onset and	tween
cate be executed ohysician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immedia cuse (Disease or injury that initiated events resulting in death) Last	Se	с	(or as a conse										
The law requires that the death certificate has been signed by the attending phanes should be detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □ Yes 2 ☑ No 9 □ Unknown	ant	1 ☐Live	utcome pf pregr birth 2 Fer nant at time of nown	tal death 3 □	Ectopic preg Other <i>(speci</i>					2	23d. Date of deliv Month	ery Day	Year
equires that en signed I	ed by P	Part II. Other significant of	conditions co	ntributing to o	leath but not re	sulting in the ur	nderlying caus	se give	n in Part I.				se contribute to t □ No 3 □ Pro		
n: The law re ficate has be or, page 2 sho	Completed	25. Was case referred to									1□ Yes	psy ormed? 2 No	24b. Were autriprior to condeath? 1 □ Yes	opsy findings ompletion of 2□No	available cause of
Physicia this certi	To Be	25. Was case referred to rexaminer? 1 Yes 2 No 27. Manner of Death	⊢	Hospital: 1 28a. Date		ER/Outpatien		Othe	r: 4□ Nu	rsing Home		dence 6	6 □Other (Speci	fy)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation Could not be determined	(Moi	nth, Day Year)	Injury	М		? ′es 2∐I	No	d. Describe f. Location (City or To	Street and	d Number or Rui	al Route Nui	mber,
ne Hospit. n 24 hours ne Funera	Medical C	29a. Certifier FS C (Check only one)	ertifying Phy edical Exami	i ner: On the l	e best of my kn pasis of examin nner stated.	nowledge, death nation and/or in	occurred at vestigation, in	the tim	e, date an pinion, dea	d place, and th occurred	d due to the at the time	cause(s) date and	and manner as a place, and due	stated. to the cause	(s)
Veithi Total	M	29b. Signature and title of	certifier	or,	Ŋ	UD			number	:123		29d. Date July	e signed (Month) 7 28,200	Day, Year) 8	
		30. Name and address of Eric Antwi-	person who a	r,M.D.	9131 I	Piscata	Print)				on,Ma	rylar	nd 20735		
St Regis	_	31. Date filed (Month, Day		32.	Regintrar's Sig	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, Month July Physician 2008 10:20P M Carol Seese Merritt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Crownsville Fairfield Nursing Center Birthplace (State or Foreign Country)
 PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □_VF 80 232-40-8828 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Precioul Examiner: ust be notified 31 once. 1 ☐ Yes 2 No **Funeral Director** MD Charles La Plata 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9910 20646 USA Charles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Scheffer Karl Seese ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20646 9910 Charles St. La Plata, MD Harrieton Merritt/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ellenboro Masonic Cent. 8/4/08 Ellenboro, WV 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FUNERAL HOME, P.A. and 40 St. Mary's Ave, La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) XO WELL IL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highway CW Olin Garnee MD 21061

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 27 2008 5:45 A M Florence L. Mitchell Ju₁y 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Southern Maryland Medical Center Clinton 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ■ M 2 🔀 F June 29,1928 North Carolina 80 577-38-8420 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1⊈Yes 2□No Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 9604 Surratts Manor Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☒ No 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Carter Carl Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9604 Surratts Manor Dr., Clinton, MD 20735 Dwight L. Mitchell - Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 08/02/08 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sanders & Sons Mortuary Service 21. Signature of Funeral Service Licensee 7908 Kincannon Pl., Lorton, VA Inter the diseas, or commications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of moch line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ YeNo 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner

permit. Pages 1 Department of H Important: If ite any injury or ot

Physician

/Medical

Examiner

Funeral

Director

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s 1 and 2 should be filed within 72 hours after death with 1 if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 2

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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To the Funeral Director; After

Physician/Medical \$ Completed Be P

Certification:

Medical

State

Registrar

the

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 ☐ Suicide 4 Homicide

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of confiler ana

6 Could not be

29c. License number D35206 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1701 Wingin Rand Fat washington mongland T. TANNER MY llian

31. Date filed (Month, Day, Year)

302008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	an/	1. Decedent's Name (First, Middle,		NET (1017			Date of Dea Month	Day	Year	3. Time of Death 1435 hrs
ની Exami	ner	RAYMOND 4a. Facility Name (if not institution,	GENE	NELS		ity Town o	r Location of D	August 6		County of Death	1435 1115
		Memorial Hospital	give street and number)			umberlan		Cau		legany	
Funeral		Social Security Number 6	. Sex 7. Age (In yrs. last bit	rthday) If	Under 1 Yea		4Hrs. 8. Date of B	irth(MM/D	DD/YYYY) 9. Birt	
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	-	Usual Residence of Decedent						10 10	1707		
w any		10a. State 10b. County		Oc. City, Town		D.					10d. Inside City Limits 1 X Yes 2 No
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with the Maryland is 23a or 28a-f sho		1 1 BEECHWOOD D	12. Was Decedent Ev	ver in U.S.	13. Was De	2 1502		? (Specify Yes or N		ISA 14. Race - Ameri	can Indian, Black,
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Me Me	70	19a. Informant's Name/Relationshi	(Type, Print)	19	9b. Mailing Ad	dress (Stre		r or Rural Route Nu			, Zip Code)
aur Zaur		SANDRA NELSON / 20a. Method of Disposition	WIFE	1 20h Blace	1 BEEC	HWOOD	DR., C	UMBERLANI Date) MD	21502 ocation - City or	Town State
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Baltimore, permit. Pages I an Department of Her Important: If ite		4 Donation 5 Other Spe 21. Signature of Funeral Service Li		Scarpe	elli Fune	eral Hon	ne, PA 8	3-8-08	C	resaptow	n.MD
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hysician		23a. Part I. Enter the disease, or co		ne death. Do r	not enter the m	node of dying	, such as card	liac or respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
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ZXUIIIII		or condition resulting in death)	Due to (or as a conseq	uence of):		5007	W W. W. W.			(107)	1
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Division tal or Attendi 13 after death. at Director: //	ertification:	2 Accident Investi 3 Suicide 6 X Could	28e. Place of Inju	ry - At home,	farm, street, fa		building, etc.				ural Route Number, City
Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certifi 24 hours affect the remaining the confinence of the second process. After this certificate has been signed by the attending the filled in by the funeral director, page 2 should be detached for use as the confinence of the	erti	4 Homicide determ		sidenc	e			Cumber	land	l Beacht , MD	wood Dr.
Di To the Hospital within 24 hours a To the Funeral completely filled	cal C	29a. Certifier 1 Certifying Phy	rsician: To the best of my	knowledge, d	eath occurred	at the time,	date and place	e, and due to the ca	use(s) an	d manner as stat	ed.
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		30. Name and address of person w Melissa Brassell, MD	no completed cause of dea Assistant Medical E			n Street,	Baltimore,	MD 21201			
St	tate	31. Date filed (Month, Day, Year) AUG 1 3 200	32. Registrar's	Signature	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ronald Jordan Napier, Sr. /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHEN BURNIE ANRIE CBNTF WASHINGTON MIRIDIUAI SALTI MOVE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/30/1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Maryland 219-38-6931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once. 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 USA 1525 Wakefield Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elvin Napier Rose Woods ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 229 Oakwood Rd., Edgewater, MD 21037 Ronald J. Napier, Jr/Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woods Family Cemetery 7/28/08 Millersville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Muri 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACTPUCTIVE KULMON **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Dage 2 should be deather attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 4 Pregnant 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d Date signed (Month, Day, Year) re and tille of certifier 29c. License number ause of death (Item 23a) (Type, Print) ame and address of person who comp

Registrar
DHMH 17 Rev 1/2001

State

31 Date filed (Month.

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:00 PM Mary Taylor Pruitt 07 2008 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wi comi 1136 a Hospice at the)a vaste1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/25/1914 Birthplace Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2X□ F Months Days Hours 94 225-18-3930 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 12 No. 9 Unknown Month Day Year 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s 1 ☐ Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2√No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) 29c. License number 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O B. F 1733 SHLISIBURY UND 21802 9 HU HAM WARIS DASTUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

JUL 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Fred Luther PALMER 1:15 aM 2008 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 🗙 M 2 🗆 F 214-28-5298 79 June 3, 1929 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 10021 Pleasant View Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No
If Yes, Give Year or Dates; 1948-68 filed within 72 hours after 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 □Yes 2 🛚 No Specify: white <u>გ</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) armed services military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H Pages 1 and 2 should be Fenton Palmer Maggie Martz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 10021 Pleasant View Dr., Hagerstown, Md. 21740 Hertha Palmer - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/08 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service License E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** STOVU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner luc on zur burial-trai Due to (or as a consequence of) Box 68760, aftending physician for use as the buria the death certificate be Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnatin the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a P.O. 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 🗌 No Completed peen PUMONEVU 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate en 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 -No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1. Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCO N915 OH 6+1 1)4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2008 AUG 0 Registrar

08-05946

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

A. Reyes-Argue		nent of Health and Mental F cate of Death	Reg. No.	
vsician/	eqistrar Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 1632 hrs
xaminer	JOSE A. REYES-ARGUETA		Month Day Year August 3, 2008	
	la. Facility Name (if not institution, give street and number) East Randolph Road / Laurie Drive	4b. City, Town, or Location of Dear Wheaton	Montgome	
	5. Social Security Number 6. Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year If Under 24H	rs. 8. Date of Birth (MM/DD/YYYY)	
Funeral Director	5. Social Security Names.	Months Days Hours Mi	n. July 10, 1981	Country) E1 Salva
Biredia	215-53-3579 1 x M 2 F 27			10d. Inside City Limit
any	10a. State 10b. County 10c. City, Tov	wn or Location		1 Yes 2 N
≱	Maryland Montgomery Silver	Spring	10g. Citizen of What	
to 28a-f show iffed at once.	10e. Street and Number	10f. Zip Code		Coditity
a or 7	12604 Denley Road	20906	U.S.A.	American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho imjury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		
or ite	1 Yes 2 X No	1X Yes 2 No specify: SA	ALVADORIAN Specify: W	hite Hispani
ral",	3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16	So Decedent's Usual Occupation (Give kind o	of work done 16b. Kind of Busin	ness/Industry
"natu Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r DENTAL ASST	retired)	Clinic
36 nin 72 than than dical	12th			
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan Completed	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Surname)	
215 be file mtal H rked o	RAFAEL ANTONIO REYES	MAKIA 19b. Mailing Address (Street and Number	I . ARGUETA	State, Zip Code)
21 nould head Mes is man ric ev	19a. Informant's Name/Relationship (Type, Print) RAFAEL REYES (brother)	12604 Denley Road S	ilver Spring, MD,	20906
MC 2 st lith an m 27 auma	20b. Pla	ace of Disposition (Name of cemetery,	Date 20c. Location - 0	City or Town, State
ore,	20a. Metrico di Bisposition 3 - Pemoval from State cre	ematory or other place)	g/15/08 BURTONS	VILLE
Page ment tant:	4 Ponation 5 Other Specify:	22 Name and Address of Facility S	anta Cruz Funeral	
3alt ermit Depart mpor njury	21. Signature of Funeral Service Licepsee	600 Kennedy St,	N.W. Washington,	D.C. 20011
	23a Part I Enter the disease, or complications that caused the death. D	Do not enter the mode of dying, such as cardia	ac or respiratory arrest, shock, or hea	rt Approximate Inte Between Onset
/sician	failure. List only one cause on each line.			Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			
	Sequentially list conditions, b			
	if any, leading to immediate Due to (or as a consequence or): cause. Enter Underlying Cause			
ed nsit	(Disease or injury that initiated events resulting in death) Last			
6 be executed sysician and burial - transit	d			
O, be execut sician and burial - tra	UNPENDED		23d. Date of	delivery
Box 68760, e death certificate be the attending physic ed for use as the but	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnat	ancy 2 Fetal death 3 Ectopic pr	2.4	Day Year
cords, P.O. Box 6876 law requires that the death certificate has been signed by the attending phy 2 should be detached for use as the Company of the control of the contro	past 12 months? 4 Pregnant at time of dea			
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for the		author in the underlying cause given in Part I	23e. Did tobacco use contr	ibute to the cause of death
P.O. es that the gened by be detach		Sulang in the anachying cases give	1 Yes 2 ✔ No 3	Probably 4 Unkn
S, P				Were autopsy findings ava prior to completion of caus
ord w req as bee			performed?	death?
Records, The law requires ficate has been sig		26.Place of Death (C		✓ Yes 2
/ital Rec ysician: The his certificate director, page	25. Was case referred to medical			✔ Other: Scene
Physic r this	1 Ves 2 No	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occur	
ding Ph		1610 hrs 1 Yes 2 ✔ N	Driver auto auto collisio	n
ivisior or Attendather death Director:	2 Accident Investigation 28e, Place of Injury - At ho	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number 1	
Division of Vital spiral or Attending Physician: nours after death. After this certificate in by the funeral director.	3 Suicide 6 Could not be determined (Specify) Local Stree		or Town, State) East Randolph Road / Laur	ie Drive , Wheaton, MD
E 6 5 E		the state and place	e, and due to the cause(s) and manne	er as stated.
To the Hos within 24 h	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.	nd/or investigation, in my opinion, death occu	arred at the time, date and pleas, and	
To To	29b. Signature and title of certifier	29c License number		ned (Month, Day, Year)
	anesa	O.C.M.E.	August 4,	2000
	30. Name and address of person who completed cause of death (Item	123a)	01201	
	Ana Rubio MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	21201	
	e 31. Date filed (Month, Day Year) 2008 Registrar's Signat	ure -		

DHMH 17 Rev 1/2001

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ,2008 August stewar /Medical 4a. Facility Name (If not institution, give street and number)
Pleasant View Nursing Home
4101 Old National Pike 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aryland arro B. Date of Birth April 22 1929 Social Security Number 220–26–7503 (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex Age **Funeral** Days Months Hours Min 1 XM 2 ☐ F 79 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Meritcal Examiner must be notified at MD. Allegany Frostburg 1 Tyes 2 No Director 10f. Zip Code **21532** 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1 Kaylor Circle, Box 612 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Kryes 2 □ No If Yes, Give Korean Year or Dates: Korean Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Convenience Store Elementary/Secondary (0-12) College (1-4or 5+) Manager unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Stewart Swach Lily ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If Item 27 is any Injury or other trauonce. Rebecca Freeland/gaurdian 14 Greene St, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State Cumberland, Maryland 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wien 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Neumonca **Physician** 101 /Medical Due to (or as a consequence of): Examiner WINIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 Demen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ √0 page 2 s this certificate 1∐ Yes 2 🔀 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 588 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 10

State Registrar MELLUM Juel 31. Date filed (Month, Day, Year)

AUG 0 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Annapolis

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			For State Registrar		State of M	larylan	d / Depa <i>Cei</i>	artmer <i>rtifica</i> :	nt of H <i>te of L</i>	lealth a D <i>eath</i>	and Me	ental Hy	giene Reg. No	20	08	26	124
	Physicia			de (First, Middle, Las							2	2. Date of De	ath Da	y 20	ď8ªr	3. Time of I	
- Contract	/Medic Examin		4a. Facility Name (If not institution, give	street and number	,	-		Town, or	Location of	f Death			. County o	of Death	1	
	Funeral Director		5. Social Security N	Number 6. Se			as <i>t birthday)</i> Yrs.		r 1 Year	If Under 2 Hours	Min. (B. Date of Bir (Month, Date) 3/13/			_	elace (State or etry)	Foreign
	/land low		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City	y Limits
	e Mary 3a-f sh iiffed	ctor	MD	Washingt	ton		Hager	stown	n							1 XYes	2 🗌 No
	with th	Dire	10e. Street and Nu	mber neo Drive				10f. Zi	p Code 2174	0			-	tizen of W		itry?	
	items 23	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces 1 Yes 2	Ever in U.S	S. 13.	Was Dece If Yes, spe			gin? (Spec , Puerto R	ify Yes or No ican, etc.)		14. Race		ean Indian,	
036	ours aff	d by	3 X Widowed	ried 2 Married 4 Divorced	If Yes, Give Year or Dates:	140				Specify:				Specify:	Whi	te	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by	(Spe Elementary/Second		ucation de completed) College (1-4or	5+)		kind of wo DO NOT i	ual Occupa ork done d use retired maker	luring most)	of working	1	16b. K	ind of Bus		dustry	
nd 2	12 should be filed within hand Mental Hygiene. 7 is marked other than " traumatic event, the Men	Be Co	17. Father's Name	(First, Middle, Last)				Tromer	marci	18. Mother	,	First, Middle		Surname		<u> </u>	
Maryland	hould be marked marked marked	၉	John D	eWitt ame/Relationship (7	Type Print)		10h Mailir		o (Stroot o	Emm		shby Route Numb			04-4- 71-	0-4-1	
	1 and 2 s Health ar tem 27 is			. Steiding						Lema			17	231	state, Zip	Code)	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Dis ty∑ Buriai 2 4 Donation	position □ Cremation 3 □ 5 □ Other (Specify	Removal from State		lace of Dispo emetery, crem iend C				Da 06/20			ocation - 0 aklan			
Balti	permit. Pages 1 Department of P Important: If ite any Injury or ot			uneral Service Licens		A L		2. Name a	nd Addres	s of Facility	Fre	dlock mont,	Fune		Home		
			23a. Part 1. Enter shock, or hea	the disease, or comp art failure. List only o	olications that cause one cause on each l	d the death	. Do oot ent									Approximate Interval Betw	veen
40/143	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	a A	1 Le		lent		Conde	si Va	ran	12	ne	~	Onset and D	eatn
	Examiner		Sequentially list co	nditions,	b							-					
Т	cuted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediaté erlying injury	Due to (or as	a consequ	ience of):										
68760,	tificate be executed ig physician and as the burial-transit	al Exa	resulting in death)	Last	Due to (or as	a consequ	ience of):			-							
687	rtificate ng phy as the	Medical	E ECHALC.		d												
O. Box	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	iF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Fetai	death 3	Ctopic Other (s	pregnancy pecify)	'				23d. Date Mor			ear
S, P.	es that igned by be deta	by Ph	Part il. Other signi	ficant conditions co	ontributing to death I	out not resu	lting in the ur	nderlying	cause give	ın in Part I.		23e. Did t	tobacco	use contri	ibute to th	ne cause of de	eath?
ord	w requir been si should I	eted	Hypen	lenia_	sigh	1	Din	me						1		ably 4 d	
Vital Records,	ician: The law certificate has ector, page 2 s	Completed							-					q.	rior to co eath?	psy findings a mpletion of ca 2 □ No	vailable luse of
fVit	Physician: this certific at director,	To Be	25. Was case reference examiner? 1 ☐ Yes 2 █	_	Hospital: 1 ☐ Inpat	ient 2 🗆 i	ER/Outpatier	nt 3 🗆 D	OA Othe	ar.		<i>Check only o</i>		6 M Othe	er (Specif	ASSIS	
on of	ding Ph. h. After thi funeral	tion:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	th 5 Pending investigation	28a. Date of inj (Month, D.	ury ay, Year)	28b. Time of Injury	M	28c. Injury Work	/at ? /es 2∐N	i	d. Describe			. , .		
Division	al or Attendi s after death. al Director: A ed in by the fi	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	jury - At hor tc. <i>(Specify</i>	me, farm, str					f. Location (City or To	Street a	nd Numbe e)	er or Rura	il Route Numb	per,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical (29a. Certifier (Check only one)	1 Certifying Phy 2☐ Medical Exam	ysician: To the best liner: On the basis and manners	of examinat	wledge, death tion and/or in	h occurred vestigation	d at the tin	ne, date and pinion, deat	d place, ar	nd due to the	cause(: , date an	s) and ma d place, a	nner as s	tated. the cause(s)	
	To the vithin com	Σ	29b. Signature and		وس ین				c. License		^		29d. Da	ate signed	(Month,	Day, Year)	
			30. Name and add	ress of person who c	completed cause of	death (Item	23a) (Tyne		000	801	14		<u> </u>	3/1	08		
		3	Dr. VAS	ANT DAT	TA 34	D M	11 37	111	AGE	STOC	ಬಬ	wv	27	140			
	Sta Registra	-	31. Date filed (Mor.	th, Day, Year)	100	rar's Signat	ure A A	graft	2								

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Cheltenham, MD Approximate Interval Between Onset and Death IWK 1WK IWK 2 WKS 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Year

4:15 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

N.Carolina

White

State Registrar

Medical

4 Homicide

(Check only one)

Monish

29b. Signature and title of certifier

Shah

Date filed (Month, Day, Year)
AUG 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garrett

32. Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 26/26 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Angust 2008 Norman Peary 4:40 PM **Physician** Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1√ M 2□ F 562-19-9973 50 09/09/1957 Director CA. Usual Residence of Decedent 10d Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 X No Director Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7852 Hickory Leaf Road items 23a 21144 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life._DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, its Item College (1-4or 5+) Elementary/Secondary (0-12) should be filed within and Mental Hygiene. DOD Analyst 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carleton Smith LaPlante Donna ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7852 Hickory Leaf Road Severn, MD 21144 Robin L. Smith Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Atlantic Crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State 08/07/08 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 851 Annapolis Road Oatr Gambrills,MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): certificate be executed ending physician and use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) signed by the a P.0. ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has autopsy perform 2 No 2 PNo 1 ☐Yes 1 ☐ Yes ospital or Attending Physiclan: hours after death. Ineral Director: After this certifica funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manur of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital within 24 hours a

To the Funeral I

completely filled 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier upital Drive Glen Burnie, M. 2016! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ate 31. Date filed (Month, Day, Year)





			For	State of M	aryland / Depa			Mental Hyg	giene		
		_	1 = State Registrar		Cei	rtificate of	Death		leg. No. 2	108	26127
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TA	Examin		4a. Facility Name (If not institution, g				r Location of Death		4c. County		
			10431 Willett		-	White 1				rles	
ı	Funeral Director			Sex 7. Aç	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 3	r, Year)	9. Birthplace Country) Mary	(State or Foreign
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					nside City Limits
	faryla shov	5	MD Charle	S	White						∐Yes 2√D¶o
	the N 28a-1 notifi	ect	10e. Street and Number		WILLE	10f. Zip Code			10g. Citizen of V	What Country?	
	with sa or the sa	Funeral Director	10431 Willett	s Crossin	ng Road	20695	5			S. A.	
	death ms 2	nera	11. Marital Status	12. Was Decedent		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-	14. Rac	e - American In	idian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 3☐ If Yes, Give Year or Dates:	No	1 □ Yes 2 [] No	Specify:	o Ricari, etc.)	Specify	ck, White, etc. ^{y:} White	•
9	tural sal Es	pa	15. Decedent's l		16a. Dece	dent's Usual Occup	ation	- 1	16b. Kind of Bu	usiness/Industry	
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	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	•			18. Mother's Nam	, , ,		,	
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Maryland	d 2 sho th and ?7 Is ma trauma		19a. Informant's Name/Relationship Barbara Simms			ng Address (Street					
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	Physician		Immediate Cause (Final disease or condition	12.	reatic	CANCE	R			Ons	set and Death
10	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
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	ng ph	Med	IF FEMALE:								
Вох	eath certifi attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	∃Ectopic pregnancy	/			ate of delivery	Year
0.	at the de by the a tached for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9⊡Unknown	t time of death 5□	Other (specify)				J	. 5
<u>α</u>	that the		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	tribute to the ca	use of death?
Records,	w requires to been signer should be a	d by						1 □ Y	es 2 □ No	3 ☐ Probably	4 Unknown
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or Vital		Be C	25. Was case referred to medical				26. Place of Dea	th (Check only or		TE Tes 200	140
<u>_</u>	dir dir	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	lence 6 □Oth	ner (Specify)	
n o	ding Ph J. After th funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		Wor		28d. Describe h	ow injury occur	rred	
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Division	Il or Attendatter deatter deatter deatter deatter l'Director: din by the	Certification:	4 ☐ Homicide determine		jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow	n, State)	oer or Hurai Ho	ute Nurriber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical Ex		of my knowledge, deat of examination and/or in						
	thin 2, the f	Medical	one) 29b. Signature and title of certifier	and manner s		29c. Licens				ed (Month, Day,	
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			30 Name and address of person wh	o completed cause of	death (Item 23a) (Type	Print)	0000	, , ,	1 0/1	6/08	
			39. Name and address of person wh	nan 51	POST OF	fice Ro	1 #304	WAL	lort n	10 2	060)
	Sta	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature		- (· · · · · · · · · · · · · · · · · · ·			/

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 414 Ronald Richard SINES, Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min 1**X** M 2□ F Yrs. Director 73 29 1934 Dec. 220-30-9555 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13012 Church Hill Court 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No If Yes, Give Specify þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Router Organ Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . c., Maryla, permit. Pages 1 and 2 should be. Department of Health and Mental Limportant: If them 27 is more any injury or oth-2 should be fi ဨ Harry Ralph Sines Ruth Ellen Zombro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Sines - Wife 13012 Church Hill Court, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 8/1/08 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 122. Name and Address of Facility Minnich Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Ö ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. Completed 24a Was an autopsy performed? Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 XNo 3 DOA Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Between Onser and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 XÚnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OfXLCT, HAGERSTOWNY

2008

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2√ ☐ No

Maryland

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Registrar

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4 Homicide

29b. Signature and title of c

31. Date filed (Month, Day,

29a. Certifier

and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** Nathalie Elizabeth SPIELMAN 30. July 11:14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 144 Plantation Drive Washington Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛣 F 220-18-2279 83 **Director** Feb. 25, 1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show Director 1 ☐ Yes 21 No Maryland Washington Hagerstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 144 Plantation Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify: \$ white Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 retail sales department store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George I. Wagner Mary Rose Knodle ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 1830 Dual Highway, Hagerstown, Maryland 21740 Randy Wagner - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 8/2/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ icate has been si 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 □Yes 2 ☑ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certific Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19414 SI DO BOLL MA 31. Date filed (Month. Day. Year State AUG 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiono

			For State of Maryland / Department of Health and M 1 - Registrar Certificate of Death		Reg. No.	2008	26130
	Physicia	an	Decedent's Name (First, Middle, Last)	Date of Dea Month	Day 25	Year	3. Time of Death
	/Medic	al	OLIVE LA CROIX SCHULER	JULY		2008	4:00PM ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 27976 OAKLAND CIRCLE EASTON		40.0	county of Death TALBO	т
rela	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day) (Voar)		lace (State or Foreign try)
	Director		013–16–7426 91 Yrs.	DEC 10	, 1916	Coun	NH NH
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Maryla	ō	MD TALBOT EASTON				1 □ Yes X □ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	1	10g. Citize	en of What Coun	try?
	th with		27976 OAKLAND CIRCLE 21601			USA	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	1. Race - America Black, White,	
30	be filed within 72 hours after death with the Maryland ital Hyglene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Yes 2 ▼ No Specify: Year or Dates:		8	Specify: WHI	
12-0036	2 hour	ted t	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind	d of Business/Inc	dustry
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7	filed will Hygien ther th	5	12 HOMEMAKER			N HOME	
yland	be fill stal H ed oth even	Be	17. Father's Name (First, Middle, Last) ADOLPH LA CROIX 18. Mother's Name CORDELI			lurname)	
	hould d Mer marke matic	၉	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura			Town State Zin	Codol
Mar	nd 2 s lith an 127 is r trau		JANET S. DAVIS/DAUGHTER 27976 OAKLAND CIRCLE,				Codey
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Ē	Page ment c ant: If ury or		1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	/28/200	8 ST	EVENSVIL	LE, MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mentic Important: If Item 27 is marked any Injury or other traumatic er once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN	A NEWN	AM FI	INERAL H	IOME PA
	70 = # g		ZOHN R MERCERO 200 S. HARRISON ST.	, EASTO	N, M	21601	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
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09/89	tificate be executed g physician and as the burial-transit	edical	d				
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. Box	the death cely the attendir Iched for use	Physician/N	in the past 12 months? 1 □ Ves 2 □ No 1 □ Ves 2 □ No		1 7	Month	Day Year
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Vital	@ D		OF Was pass referred to modical	1□ Yes	2 2 No	death? 1 ☐ Yes	2 No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No No No No No No 1 Nursing Ho			Other (Specific	
9	ding Phys 1. After this funeral dii	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe h			y)
DIVISION	Attending I death. cctor: After y the funer	atio	2 Accident investigation M 1 Yes 2 No				
Š	or Atteno after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		Number or Rura	il Route Number,
_	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	and deep 1	/ \		teted.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time,	date and	place, and due to	the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of confitier 29c. License number		29d. Date	signed (Month,	Day, Year)
	TLS		Vaude/ Coprounte is D D004428:	2	7)	- 28-0	8
	1		30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)	1		<u> </u>	V
		•	31 Date filed (Month Day Year) Registrar's Signature				
	Sta Registr		31. Date filed (Month, Day, Year) 2008 . Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27 JULY 2008 10:30AMM RICHARD JOSEPH SILVA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHESTER MALLARD BAY CAMBRIDGE 8. Date of Birth (Month, Day, Year) FEB 8, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 M 2 □ F 93 CONNECTICUT Director 042-07-9824 Isual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 ☐ No Director MD DORCHESTER CAMBRIDGE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 520 GLENBURN AVE USA Funeral 21613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ ANTONIO SILVA MARGARET MAY MURPHY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important; If Item 27 is any Injury or other trau once. 297 BARBER RD., TRAPPE, MD 21673 JAMES BRYAN/PER.REP. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 7/31/2008 HURLOCK, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 105RPh M. CFSP STROWSh. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 140 CATO /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1. hal 1 Yes 2 → 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ 100 PACT 24a. Was an autopsy perform bullation 1 2 100 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/4/0 Hospital: Other: 4 lursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed Records, P.O. Box 68760, physician attending the nas certificate | Division or Vital this or Attending Patter death. After 24 hours a Hospital

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page 2 s

funeral director

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Medical

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>

uth and Mental H

To the I within 2. TLS 4+VA

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certific

013

31. Date filed (Month, Day, Year)

6 ☐ Could not be



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			Please Type or Print in Bl. State of Maryland	/ Dena	rtment of H	lealth and M		_	
Amen	ded,#10)a,	a FOI	Cen	tificate of L	Death TLS	iornai riy	Reg. No. 200	8 26 1 3 2
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	- 2M	4b. City. Town, or	Location of Death	July	21 200 4c. County of Dea	
	Examin	er	The Johns Hopkins Hospital		Baltimore				
	Funeral	10	5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	th 9. Bi	rthplace (State or Foreign ountry)
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	ryland thow at	_	10a. State 10b. County 10c. City, To	own or Loc	Seafor	i			10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	Director	THE NEXT	forc	1-				1 ☑ Yes 2 ☐ No
	with the		10e. Street and Number		10f. Zip-Code	2		10g. Citizen of What C	ountry?
	ms 23	Funeral	8651 Garden Lane 11. Marital Status	13. V	1997 Vas Decedent of H	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No	USA 14. Race - Am	
92	or Ite		1 Never Married 2 Married 1 Yes 2 No	- 1	Tes, specify Cuba	Specify:	nican, etc.)	Black, Whi	
Ö	hours ural",	ed by	3 Widowed 4 Norced If Yes, Give Year or Dates: 15. Decedent's Education 1	16a. Deced	lent's Usual Occup	pation		16b. Kind of Busines	
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Maryland 21215-0036	should nd Mer marke	၉		19b. Mailir	g Address (Street	Rosema and Number or Rur		Smith ber, City or Town, State,	Zip Code)
	alth ar 27 is 27 is ir trau		Rosemary Martin/ Mother	865	1 Garde	n Lane.	Seafo	rd.De.199	73
Baltimore,	es 1 a of He f Item r othe		20a. Method of Disposition 20b. Plac	netery, crem	natory or other plac	:e) ;		rd, De. 199 20c. Location - City o	
Ę	t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Mace		ia Cem.		6-08	·	
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			23a. Part 1. Em. the disease, or complications that caused the death. I shock, or hear failure. List only one cause on each line.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death
42	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Actic	closi	5				
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Box 687	certificate ding phys	Medi							
×	th cert ending	ian/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de	eath 3	Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
	ne death the atten ched for u	Physician/Medi	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	n 5_	Other (specify)				
, P.O.	v requires that the death certificate been signed by the attending physi should be detached for use as the	by Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the u	inderlying cause gi	iven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records,	quires in sign ould be						15	Yes 2 No 3 F	Probably 4 🗌 Unknown
ecc	law requas been 2 shou	Completed					24a. Was	an 24b. Were a prior to death?	autopsy findings available o completion of cause of
E H	sician: The law certificate has b						1 🗌 Yes	2 No 1 □ Ye	es 2 🗆 No
<u>Xit</u>	Physician: this certifica aral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing Ho	` .	idence 6 🗆 Other (Sp.	ecify)
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isio	Attending or death. sctor: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home	farm str		Yes 2 No	28f Location	(Street and Number or	Rural Route Number
Div	i or Attending Phy: after death. Director: After this d in by the funeral d	Certification:	4 Homicide determined building, etc. (Specify)	i, iaiiii, siie	set, lactory, office			wn, State)	narai rioate ramboi,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifier (check only 2 Medical Examiner: On the basis of examination						
	o the l	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License	e number		29d. Date signed (Mor	nth, Day, Year)
2K	TLS		MD MD		RES	5-000		JULY 2	1,2008
3-	- 3	5 3	30. Name and address of person who completed cause of death (Item 2 NATALIA GLEBOVA			600	North W	olfe St, Baltim	ore, MD, 21287
	Sta Registi		31. Date filed (Month, Day, Year) 2008 Registrar's Signature	Ass	4				

			For State	State of Marylar			it of Hea e of De		vientai H		0000	061	<u> </u>
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lilicai	e or De	eauri ————	2. Date of D	Reg. No.	2008	3. Time of Deat	کک
	Physici		Robert Atienz	o ConTuita					Month	Day	Year	4:30P	
	/Medic Examin	- 1	4a. Facility Name (If not institution, give s			4b. City	Town, or Lo	ocation of Death	July	27 4c. (2008 County of Deat	h	
فر	LAGIIII		3700 Mt.Aventine	Road			India	n Head			Char	les	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Unde	r 1 Year 1	f Under 24 Hrs. Hours Min.	8. Date of B	Birth Day, Year)		hplace (State or Foreuntry)	eign
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	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City Lin	nits
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	the 1 28a- notifi	Director	10e. Street and Number			10f. Zi	o Code			10g. Citiz	en of What Co	untry?	
	3a or	Ö	3700 Mt. Aventine	Road			2064	.0			USA		
	ms 2	Funeral		12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Vas Dece		eanic Origin? (S Mexican, Puerl	pecify Yes or N	No- 1	4. Race - Ame Black, Whit		
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	<u>م</u>	1 ☐ Never Married Ž Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		i res, spe i ☐ Yes		Specify:	o rican, etc.)			hite	
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0	filed I Hyg other	Be	17. Father's Name (First, Middle, Last)				* 1	8. Mother's Nar	ne (First, Midd			- Constitue	
Maryland	uld be Jenta rked tic ev	TO B	Paul SanLuis, Sr.					Maerie	Etta H	ockma	n		
ary	short and N s ma		19a. Informant's Name/Relationship (Ty	pe. Print)	1	_		d Number or Ri		-			
	and ealth n 27 ner tr		Robert SanLuis/Son	Teer				e Fran					
altimore,	ges 1 t of H If itel or oth		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ F	lemoval from State	Place of Dispo cemetery, crei	natorý or	other place)	i	Date	20c. Lo	cation - City or	Town, State	
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	ted nsit	Examiner	Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	O a l a	Addence on.		10	- 11-	A	/	1-		
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_	tificat g phy as the	ledi									-		
Box	th cer endin	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome pf preg 1□Live birth 2□Fe		Tectopic	pregnancy			2	23d. Date of de		
П	ed for	sicis	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at time of 9□Unknown		Other (-	Month	Day Year	
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	law requires that the death certi as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions co	intibuting to death but not re	sulling in the u	ilderlyllig	cause given	III Fait i.				robably 4 Unkn	
5	w require been signature should b	eted											
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or Vital Records,	ding Physician: n. After this certific funeral director,	o Be	25. Was case referred to medical examiner? 1 ¼ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	□ FR/Outpatie	nt 3 🗆 🗈	Othor	26. Place of De			6 ∐Other (Spe	noifu)	
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<u>o</u>	Attending Physician: r death. ector: After this certification of the funeral director, in	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M		es 2∐No					
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	To the within 2 To the complet	Me	29b. Signature and title of certifier		,	2	9c. License r				te signed (Mor	•	
			+ yarra	M. Jagan	~		D0050	0883		Ju	ly 28,	2008	
	0		30 Name and address of person who c	omnleted cause of death (It	em 23a) (Type.	Print)							
_	185		Yahia M. Tagouri			app P	lace,	La Pla	ta,MD	20646			
10	St	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Sig	nature	brass	20						

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mes Warren S		Sta For State	ite of Marylan				nd Mental I	Hygiene	0.0	00 0010
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, N		4a. Facility Name (if not institution		er)	4b. C	City, Town, o	or Location of Dea		4c. County of Deat	h
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Funeral	10.7	5. Social Security Number	6. Sex 7.	Age (In yrs. la	_	Under 1 Ye			(MM/DD/YYYY) 9. Bi Fore	
Director		577-42-2438	1 X M 2 F	74	Yrs.	Months Da	ys Hours M	Aug. 10		ountry)Illinois
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ne Ma or 28	Director	2312 N. Upton	Street			2220			USA	,
with the same of t		11. Marital Status	12. Was Deced	ent Ever in U.S				Specify Yes or No-	14. Race - Ame	rican Indian, Black,
leath r item	Funeral	1 Never Married 2 X Ma	1 X Yes	2. No		specify Cuba	an, Mexican, Pue	rto Rican, etc.)	White, etc.	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be	Albert Getten S	Stone				Esther	-Jane Hu	ighes	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationsh Louise-Crawford	nip (Type, Print)						ber, City or Town, Sta	
ore, MD es I and 2 sho of Health and If item 27 is		Feagin Stone	/ Wife					rlington,	Va . 2220	
of Her tr		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from		Place of Disposition rematory or other p				•	
Pagement tant:		4 Donation 5 Other Sp		Met	ropolita				Alexandr	ia, Va.
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		21. Signature of Funeral Strvice	Licensee					eVol Fune		DC 20007
Physician	-	23a. Part I. Enter the disease, or failure. List only one cause	complications that cau	sed the death.	Do not enter the n	node of dyin	g, such as cardia	c or respiratory arre	st, shock, or heart	n, DC 20007 Approximate Interval
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Box 68760, e death certificate be the attending physic of for use as the buring chest.	N/N	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?		tcome of pregi	nancy ₂ Fetal o	death 3	B Ectopic pre	gnancy	23d. Date of deliver	Day Year
ox 6 tth cer tttendi	sicia			nt at time of de	- 41-	(Specify)			1	
. Bo. the deat	Physician/Medi	Part II. Other significant conditi	9 Oliknow		esulting in the unde	arlying cause	e given in Part I	23e Did to	bacco use contribute	to the cause of death?
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be refeath. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri		Tare II. Other significant contain	ions contributing to t	iegan bot not n	ssulfing in the unit	snying oads	c given in ruici.			obably 4 Unknown
ords, w require us been si	Completed by				· · · · · · · · · · · · · · · · · · ·		-	24a. Was a		autopsy findings available
COL law r e has b	npl							autop:	med? death	
tal Reco tian: The law certificate has		25. Was case referred to medical	-			26 Pla	ace of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No
Vital F hysician: this certifi Il director,	Be c	examiner?	(Hospital:	patient 2	ER/Outpatient 3		Othor		Residence 6 🗸 Otl	ner: Scene
n of \ ding Phy After th funeral	: To	1 Yes 2 No 27. Manner of Death	28a. Date of	f Injury	28b. Time of Injur	ry 28c. ir	njury at Work?		now injury occurred	
On endin sath. or: A	tio	1 Natural 5 Pend			FOUND: 1010 hrs	1_	Yes 2 V No	Subject drov	wned	
Division of Vital Records, tal or Attending Physician: The law requirers after death. "In Director: After this certificate has been sided in by the funeral director, page 2 should be	iţi				ome, farm, street, f	actory, office	e building, etc.	28f. Location (S or Town, S		Rural Route Number, City
Divis	Certification:	4 Homicide deter	mined (Specify)	Bay				Chesapeake E	Bay, Prince Frederi	ck, MD
		29a. Certifier 1 Certifying PI (Check only one) Medical Exa	hysician: To the best miner: On the basis of	of my knowled	ge, death occurred	at the time,	, date and place,	and due to the caus	e(s) and manner as s	tated.
To the H within 24 To the Fa	Medical	29b. Signature and title of certifie	and manner sta	ted.		_	ense number	os at the time, tale	29d. Date signed (f	
20	_	A H A O A	la 1011	(1	C.M.E.		July 28, 2008	
		30. Name and address of person	who completed assista	of death (Its-	232)	0.0				
-			wno completed cause sistant Medical E		111 Penn Str	eet, Balti	more, MD 21	201		
S	tate	31. Date filed (Month, Day Year)	32 Reo	istrar's Signat	12 Arest	2)				
Regis		JUL 3 0	2008	ever to	- Johnson	1				

Box 68760. P.O. Records, Division of Vital

DHMH 17 Rev 1/2001

Registrar

3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Schmitt /Medical July 25, 2008 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Examiner Silver Spring Bel Pre Health & Rehab. Center Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Year) Months Days Hours Min. **1**√□ M 2□ F Director 214-70-3824 Sept. 17, 1955 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10h. County the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No 28a-f Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with or Items 23a or 11014 Marcliff Road 20852 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Restaurant filed marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fill fleath and Mental H tem 27 is marked ott other traumatic even Thomas J. Schmitt Jean Tronoski ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any injury or other trau Thomas J. Schmitt/Father 11014 Marcliff Road, Rockville, MD 20852 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ■Burial 2 Cremation 3 Removal from State August 5, Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. S and 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Ever the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 I Unknown 9 Unknown <u>~</u> ģ been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pancreatitis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital e Hospital or Attending Physician: 724 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P D56691 July 25, 2008 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Ghousia Sultana, MD 12107 Heritage Park Court, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 30 2008 Registrar

			For	State of Maryland		rtment of F		Mental Hy	giene				
			State Registrar	Reg. No.									
	ysicia Medic		1. Decedent's Name (First, Middle, L. Jack	Norman	Swee	t		2. Date of De Month July	26, 200	8 7:55p M			
3. Al.	camin	-531.3	4a. Facility Name (If not institution, g				r Location of Deat	h 4c. County of Death					
<i>y</i>	8		11624 34th		-4 5 1-45 5- 1	Belts	ville	0.00-40		ce George's			
Fur Dire	eral ector	0	127-03-7362	Sex 1 M 2 □ F 7. Age (In yrs. le 9 2	Yrs.	Months Days	Hours Min.	(Month, Da	th ey, Year) 1/1915	9. Birthplace (State or Foreign Country) New York			
and			Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits			
Maryli f sho	Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ō	MD Prince George's Beltsville 1\vec{M}Yes 2□No										
h the		irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?			
th wit		alD	11624 34th	Place		20	705			USA			
if yiellid AIA 13-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Hygiene.		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ½Yes 2 □ No 1 9 4 If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2☐No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	9- 14. Rac Blac Specify	e - American Indian, ck, White, etc. White			
72 hou		ted	15. Decedent's (Specify only highest of	Education	16a. Deced	lent's Usual Occup	ation	rkina	16b. Kind of Business/Industry				
ithin in i		Completed	Elementary/Secondary (0-12)		kind of work done OO NOT use retired 1 Carri		ткину	U.S.Post Office					
filed v Hygie	nt, th	ပ္ပ	17. Father's Name (First, Middle, La.	st)				me (First, Middle					
vuld be Mental	ient of result and Mental nt: If Item 27 is marked o iry or other traumatic eve	To Be	Faye Sweet					Anderse					
and 2 short			19a. Informant's Name/Relationship Robert Brian			g Address (Street 4 34th				State, Zip Code) . 20705			
Pages 1 annot the ment of He			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 6 ☐ Other (Spec	☑Removal from State S+	ace of Dispon emetery, cren Augus	sition (Name of natory or other place Stine Co	em. 8/0	Date 1/2008	20c. Location - N . Bar	City or Town, State			
permit. Pages Department of Important: If It	any inju		21. Signature of Funeral Service Lic	ansed In In	1 ²²	HTE TOPAd TOP	ssRIWALD umbia B	I FUNE	RAL SEU	RVICE,P.A. pring,Md20910			
			23a. Part1. Enter the 1 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Physic			Immediate Cause (Final disease or condition resulting in death)	_a. Dementia						Onset and Death 5yrs			
*	physician and the burial-transit the burial-transit		Due to (or as a consequence of):										
ACC CONTRACTOR		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause chiscase of injury	b Due to (or as a consequ	ence of):								
cuted		Examin	resulting in death) Last Due to (or as a consequence of):										
cate be executed physician and		I Ex											
cate be ex	the b	dical		d									
ath certifi	use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar					23d Da	ite of delivery			
the death	sched for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month Day Year			
res that	be deta	by Pł	Part II. Other significant conditions	tribute to the cause of death?									
v requires	cate has been signed by the attending p page 2 should be detached for use as	eted		Yes 2万No 3☐ Probably 4☐Unknown									
To the Hospital or Attending Physician: The law requires that the death certifiath 24 hours after death.		Completed		24a. Was auto perfo 1 Yes	utopsy prior to completion of cause of death?								
VILCAL siclan: certifical	rector	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ath (Check only									
Phy C	eral d	: To	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		4 🗀 Nursing i	7	sidence 6 Other (Specify) e how injury occurred				
STOTI tending leath. tor: Afte	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury		k? Yes 2∐No						
al or Afte		Certification:	3 ☐ Suicide 6 ☐ Could not determine	me, farm, str	eet, factory, office			on (Street and Number or Rural Route Number, Town, State)					
ne Hospit n 24 hours ne Funera	pletely fills	edical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To th	To th	Me								. Date signed (Month, Day, Year)			
9			Muchael Beral D26287							July 29,2008			
- 0			30. Name and address of person when Michael Be				Ave.#	107 Col	lege P	ark,Md 20740			
R	Sta egistr		31. Date filed (Month, Day, Year)	Registrar's Signat	ure	10	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHARLES Month Day Year SYMONS 22:10 M AugusT 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frostburg Allegany Frostburg Village Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 17 1919 Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 220-07-6128 1**XX**M 2 □ F 89 Months Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits пs 23a or 28a-f show Allegany Lonaconing XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 21539 10g. Citizen of What Country? Inited States 88 West Main St. Funeral tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐No Specify: þ Specify: 3 Widowed 4 Divorced "natural" Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Milk College (1-4or 5+) Delivery Man 7 is marked other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ε. Symons Clara Poland P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traionce. Wilma Symons/ wife 21539 88 West Main St, Lonaconing, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. View Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 08/06/ XXBurial 2 Cremation 3 Removal from State Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home ayre 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac /Medical Due to (or as a consequence of): or Fibrelation Examiner Sequentially list canditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 1 No 24a. Was an certificate has autopsy performed 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ⊠ No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours after death To the Funeral Director: completely

> Muhammad Naeem, MD, 31. Date filed (Month, Day, Year) State AUG 0 4 Registrar 2008

625 Kent Avenue, 32. Registrar's Signature

OM 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

D0066150

Cumberland, MD

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Рм Louis Marshall Thompson, Jr. August 4, 4:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20885 Oakland Hall Road St. Mary's Avenue 8. Date of Birth
(Month, Day, Year)
July 20, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 X M 2 | F Months Days Hours Country) \Maryland 217-44-2833 Ĩ924 84 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20609 20885 Oakland Hall Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14 Race - American Indian 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖾 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Eleanor Harris Louis Marshall Thompson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20885 Oakland Hall Road, Avenue, Maryland 20609 Rose Lee Thompson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August Date 1 Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 8, 2008 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

Physician /Medical Examiner requires that the death certificate be executed and buriat-trar P.O. Box 68760, physician

attending

the

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has

this certificate

After t

the Funeral Director; Af

within 2. the

funeral

Be

Certification: To

Medical

State

29a. Certifier

(Check only one)

Division of Vital Records,

Hospital or Attending Physician:

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination in pullified

Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic successions.

72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

2

Examiner Physician/Medical the as use ξ signed I ş Completed page 2 s

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 2 ☐ Accident 5 Pending Injury investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

40055751

29c. License number

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p

32.

40900 Merchants Lane, Suite 205, Leonardtown, Maryland 20650 Schmidt Dr. Jennifer

31. Date filed (Month, Day, Year) AUG 0 7



Registrar DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month PATRICIA TYLER /Medical July 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis HealthCare -The Pines Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 □ X Director 215-38-2270 76 JAN 17,1932 Usual Residence of Decedent 10c. City, Town or Location 10a. State show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Patricia Tyler Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 NURSING ASSISTANT HEALTH CARE 7 Is marked other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil f Health and Mental H tem 27 Is marked ott Be EDWARD S. STOOPS 2 FRANCES KINNAMON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troone. MICHAEL L. TYLER/SON PO BOX 277, GREENSBORO, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 7/31/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licen 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 Ustrouski C.F.S.P. Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wemia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tran Due to (or as a consequence of) Box 68760. physician requires that the death certificate be the use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown P.O. 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by sign 1 | Yes 2 | No 3 | Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After Natural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIO DUTCHMANS (ROWL 31. Date filed (Month, Day, Year)

JUL 2 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 9:40 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Weeks

months

4. gars

Year

Day

Month

1XYes 2 □ No

MARYLAND

Talbot

USA

Black, White, etc.

within 24 hours a

To the Funeral I

completely filled To the Hospital

TLS 8

Medical

State Registrar 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

32. gistrar's Signature

JUL 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year JUIY 27, 7:25 **Physician** James Robert Tomerlin /Medical 4b. City, Town, or Location of Death **Timonium** 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice **Examiner** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**3**€ M 2 □ F 052-42-5989 Virginia June 21, 1948 Director 60 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mariest Examination of the context and context a 10a State 10b. County 1 ☐ Yes 2X No Director MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20715 13115 Idlewild Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1\text{Yes 2 \sum No} No If Yes, Give Year or Dates: 1970-80 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: Be Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government, E.P.A. Research Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Benjamin Edward Tomerlin Dolores Ruth Schempp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20715 13115 Idlewild Dr. Bowie, MD Carol J. Tomerlin / Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2008 Crematory Alexandria, VA 22. Name and Address of Facility 21. Signature of Funeral Service Lice Beall Funeral Home Bowie, MD 6512 NW Crain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Ener Union Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2X No Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1∐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c funeral dire Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and a investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated. 29a. Certifier investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar

DHMH 17 Rev 1/2001

27

JAMES TOMERLIN

30. Name and address of person who completed cause of death (Item 23a)

ERNESTINE WRIGHT

VALLEY RD.

MD 21093

TIMONIUM.

vpe, Print)

2300 DULANEY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Betty Ann Waldt 5:47 P M 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 12, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1925 Days Months 1□M 2፟M F 82 578-26-3892 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, Inc Medical Examiner must be notified at 1 ∐Yes 2MiNo Middletown Director Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21769 United States 9227 Baltimore National Pike death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after ntal Hygiene. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Ire Magnes, price. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Waldt / Son 9227 Baltimore National Pk., Middletown, MD 21769 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery Aug. 8, 2008 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, MD 21701 MO1473 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car lac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Day myocarsha Frankow /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed burial-transit Exami and Due to (or as a consequence of): P.O. Box 68760 signed by the aftending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Hypertension page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an omen certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) ٩ 2 ER/Outpatient 3 DOA 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matrice description.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar 29b. Signature and title of certifier

G5 C Inom. 31. Date filed (Month, Day, Year) AUG 1 3 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick MD

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Of Maryland / Department of Health and Mental Hygiene Certificate of Death													
		1. Decedent's Name (First, Middle, Last)									Reg. No. 2. Date of Death			3. Time of Death		
	Physician Samuel S Webb									Month	Day	Year	/200 A.M			
. 4	/Medic Examir		4a. Facility Name (If not institution, give street and number)						Town or	Location	of Death	July		SCOS	7-007	
	Examili	ier	Washington County Hospital						4b. City, Town, or Location of Death Hagerstown					4c. County of Death Washington		
	Funeral		5. Social Security Number		Sex	7. Age (In yrs	. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day		9. Birthp	lace (State or Foreign	
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	he M.	ect	Maryland	Washi	ngton		Wi	lliams		†	_					
	with t	늅	10e. Street and Number					10f. Zip					I0g. Citizen of		try?	
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it as fudical Examination must be notified at once.	Completed by Funeral Director	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates; 1 □ Yes 2 No Specify:						igin? (Sp i, Puerto	ecity Yes or No- Rican, etc.)	ce - Americ ck, White, e fy:					
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Baltimore, Maryland	iges 1 nt of h : If ite or ol		XX Burial 2 Cre	mation 3 [State 20b.	Place of Dispo cemetery, crei	natory or oth	ne of her place	e)	ı	ate	20c. Location	- City or To	wn, State	
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	_		23a. P. T. Enter the dis	ease or cor	nnlications that	caused the dea								ort,	MD 21795	
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oʻ	an ar rial-tı	EX	resulting in death) Last			(or as a consec	quence of):									
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Вох	leath certifi attending for use as	an/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 1 Unknown 1 Vestal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year					
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Division	Atter dea ctor	fica	3 ☐ Suicide 6 ☐	Could not I	ho	e of Injury - At h ing, etc. (Speci	l nome, farm, str			00 = =	-	28f. Location (S	treet and Num	ber or Rura	l Route Number,	
Ö	al or Attendin s after death. Il Director: Af ed in by the fur	erti	4 Homicide	determinet	build	ling, etc. (Speci	ify)	,				City or Tow	n, State)		· · · · · · · · · · · · · · · · · · ·	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one)	wedical Exa	aminer: On the t	ner stated.	ation and/or in	vestigation,	in my op	oinion, dea	ath occur	ed at the time, o	date and place,	and due to	the cause(s)	
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DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of N	Maryland				nd Mental Hy		008	26145
		۰,	Registrar Decedent's Name (First, Middle)			007	imodic or i	Dodin	2. Date of D	eath		3. Time of Death
	Physicia /Medic		Laura	Jean	Whit	eside	es		Augus	$t \stackrel{Day}{1}, 2$	0 0 8 °	3:00A.™
	Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, Town, or			4c. Cour	nty of Death	
			12122 Heat				Hager				shing	
	Funeral Director		5. Social Security Number 218–20–5673	6. Sex 1 □ M ¾ □ F	Age (In yrs. la 81	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. Novembe:	^{rth} 14 ^r , 19	26 Ma	lace <i>(State or Foreign</i> tryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				1	0d. Inside City Limits
	Maryla f shoried at	힏		ington			rstown					1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Coun	try?
	ath wi		12122 Heath				2174				S.A.	
_	ter de	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marri	12. Was Decede Armed Force 1 Yes 2	s?	3. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	D- 14. F	lace - Americ lack, White,	
3-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or other traumatic event, the M. dical Examiner must be notified at once.		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:			I∐Yes 2XXINo	Specify:		Spe	cify: Wh	ite
<u>.</u>	"natur dical	etec	15. Decedent (Specify only highes	r's Education st grade completed)		16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most	of working	16b. Kind of	Business/Inc	dustry
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ana	be filed ntal Hyg id other event, 1	Be C	17. Father's Name (First, Middle,	Last)		-		18. Mother	's Name (First, Middle	, Maiden Surn	ame)	
ylai	ould b Menta narked natic e	2	Charles)avis			adys		Quil	
Mar	d 2 sh th and traum traum		19a. Informant's Name/Relationsl Cyril G. Whites	,	usband				r or Rural Route Numi			. ,
ē,	s 1 and if Health item 27 other to	1	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	r. Dr.TA	ve, hagerst		n - City or To	
Ē	Pages nent of ant: If its ury or o		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from Sta pecify)	le		Cremato		08-01-08	Hagers	town, i	Maryland
Saltimor	ermit. Pepartr nports ny Inji		21. Signature of Funeral Service	Licensee		Ar	Name and Addre	ss of Facility Coffma	n Funeral Street, H	Home,	Inc.	
	207.60		23a Part1 Enter the disease or	complications that cause	ed the death	Po not ent	East And	<u>tietam</u>	Street, F	lagerst	own, M	d. 21740
	Physician	Œ (23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	7		ig, sucii as c	cardiac of respiratory i	irest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. 713/10 Du (or a	as a consequ	-	nentia					years_
	Examiner		Sequentially list conditions,	b								
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Linear broads pring Cause (Disease or injury that initiated events	Due to (or a	as a consequ	ence ot):						
'n	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or a	as a consequ	ence of):						
-	ate be nysicia he bur	ca		d								
DO X	certifica iding ph	sician/Med	IF FEMALE:	23c. If yes, outcor	ne of pregner	act.						
. DOX	death e atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live birth 4 ☐Pregnant	2 ☐ Fetal t at time of de	death 3□]Ectopic pregnancy] Other <i>(specify)</i>	/			Date of delive Month	Day Year
r Ö	at the I by the stache	Phys	9 ☐ Unknown	9□Unknowr								
Š,	The law requires that the death ite has been signed by the atten bage 2 should be detached for u	by	Cerebro vasc	-		_	nderlying cause give	en in Part I.		tobacco use co	,	e cause of death? ably 4 □Unknown
ecords,	w requ	Completed by	Cereorovasc	arai Acc	Idell	1			24a, Was			
ב ב	The lay le has age 2	dwo						_	—— auto	ormed? /	death?	psy findings available npletion of cause of
ם ע	ilan:	Be C	25. Was case referred to medical examiner?					26. Place	1 Yes of Death (Check only	2 DMo one)	1 🗆 Yes	2 N0
2	Physic this of al dire	ျှ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa			t 3 DOA Oth	4 🗀 Nur	sing Home 5 Res			/)
	ding I h. After funer	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year)	28b. Time of Injury	Worl	yat k? Yes 2⊟N		how injury occ	curred	
VISIOII	Atten ector by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of	I injury - At hor etc. <i>(Specify)</i>	me, farm, str	eet, factory, office		28f. Location	(Street and Nu	mber or Rura	l Route Number,
5	ital or irs afte ral Dii	Cert								wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basis and manner	s of examinati	vledge, deatl on and/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, deat	d place, and due to the h occurred at the time	cause(s) and , date and plac	manner as st e, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	r			29c. License			29d. Date sig		
			Cynthia					7451		Augus	st 1, 0	2008
51	4-5		30. Name and address of person Cynthia Kuthner	who completed cause o	f death (Item	23a) (Type, 214 Pc	Print) craduse C	Churc	h Road, h	lagers	town 21745	Maryland
	Sta Registra	-	31. Date filed (Month, Day, Year) AUG 0	32. Re	strar's Signati	ure						
	, rogiotii				State o	17 1	back					

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2:00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Catherine Marie Williams Ju1_y 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death St. Mary's 24212 North Patuxent Beach Road California | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | September 26,1946 | District of Columbia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months 61 214-52-3971 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📆 No Maryland California St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 24212 North Patuxent Beach Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married 1 □Yes 2 🕅 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Service Advisor Tractor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Maddox Catherine Marie Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Warren Williams / Husband 24212 North Patuxent Beach Road, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery of Laurel Grove 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mechanicsville, Maryland 4, 2008 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or comshook, or heart failure. List only Approximate Interval Between Onset and Death nbications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest yone cause on each line. Immediate Cause (Final tag TV Metartatic Len than year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it Medical Examination to confiled at once.

Baltimore, Maryland 21215-0036

Exami and -tran burialattending physician for use as the buria Physician/Medical signed by the a Be Completed by s certificate has b irector, page 2 sl director, Certification: To After this funeral of nours after death.

neral Director; A
filled in by the for

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	er (specify)		Month Bay Tear			
þ	Part II. Other significant conditions	contributing to death but not resulting in the underly	ing cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown			
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes → No			
Be	25. Was case referred to medical examiner?		26. Place of Death (C					
일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	me 5 Residence 6	B ☐ Other (Specify)				
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	1	Work?	28d. Describe how injury	y occurred			
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
Medical	29a. Certifier (Check only one)	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)					
Σ	29b Signature and title of certifier		29c. License number	29d Dat	e signed (Month, Day, Year)			

29c. License number

HOLLY WOOD

D54346

29d. Date signed (Month, Day, Year)

08

B. SAJJA

State Registrar

Date filed (Month, Day, Year) AUG 0 4 2008

29b. Signature and title of certifier

SC Gaby



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA

To the Hospital of within 24 hours at To the Funeral D

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26147

		1- For State Registrar			Cert	ificate of	Death				Re	g. No.		, , , , , , , , , , , , , , , , , , , ,
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle Elsie M.		Month Doy						Year	3. Time of Death			
		4a. Facility Name (if not institution RT. #197 & Morris Driv	n, give street ar	nd number)	·	4	city, Tow	, or Loca	ation of De		uly 20, 20	4c. Cou	nty of Death	
			6. Sex	7 000	e (In yrs. las	+ hirthday)	If Under 1	Vear I	Under 24	Ure 9	Date of Bir			thplace (State or Foreign
Funeral Director		214–12–1727	1 M 2		86			$\overline{}$			10/29/		Co	ansas
any	- }	Usual Residence of Decedent 10a. State 10b. County			10c City T	own or Location	ın.							10d. Inside City Limits
* .	5		e Georg	e's	Laui									1 Yes 2 X No
Maryl 28a-i d at o	Director	10e. Street and Number					10f. Zip Co	de	_		1	0g. Citizen o	f What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.		102 Bryan Ct	. #1	03				2070	7			US	Α	
leath w	uneral	11. Marital Status 1 Never Married 2 Ma	arried Arm	ed Forces?	Ever in U.S	If Ye	s, specify C	uban, Me	exican, Pu		fy Yes or No can, etc.)		Race - Amer Vhite, etc.	ican Indian, Black,
after	by F		orced If Yes, Giv or Dates:				Yes 2 X						ify: Whi	
hours natur Exam		15. Decedent's Education (Spec				16a. Decedent during mo	s Usual Occ st of working					16b. Kind o	of Business/	'Industry
36 in 72 han "	Completed	Elementary/Secondary (0-12)	Colle	ege (1-4 or :	5+)	Cleric	al tan	oi et					TT C	Government
-00, d with giene ther t	틧	17. Father's Name (First, Middle,	Last)			CTELIC	ar cy		fother's N	ame (Fi	rst, Middle, I			GOVELIMENT
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	Be	John Yaruta	,						Clara	a Ba	rtkosł	ci	,	
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene important: If tiem 27 is marked other thingury or other traumatic event, the Mediany		19a. Informant's Name/Relations				19b. Mailing					al Route Nun	nber, City or	Town, State	e, Zip Code)
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic		Carolyn Crutch	nfield	/ Dau	-						aurel			
s l an frea frea frea frea frea frea frea frea		20a. Method of Disposition 1 Burial 2 Cremation	3 Remo	val from Sta	20b. Pi	ace of Disposi ematory or oth	ion (Name o er place)	f cemete	ery,		ate	20c. Locat	tion - City o	r Town, State
Baltimore, bernit. Pages I ar Department of Hei Important: If ite	Į	4 Donation 5 Other Sp			Meti	Cremat			7	7/29	/2008	Alex	andri	a, VA
Balti permit. Departm Imports injury o	Ī	21. Signature of Funeral Service	Licensee	/		22. N	ame and Ad	ress of F			all Fi			
	4	flerio K	ala	1			12 NW					vie. M		
Physician /Medical		23a Part I. Enter the disease, or failure. List only one cause	on each line.				e mode of d	ying, suc	h as cardi	ac or re	spiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and
xaminer	İ	Immediate Cause (Final disease or condition resulting in death)	a. Mulitple		orce Injust equence of)									Death
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frate be executed g physician and the burial - transi	/Medical	UNPENDED	AMEN	DED										
760, ficate be ex g physician the burial	ş	IF FEMALE: 23b. Was decedent pregnant in th		-	me of pregna			. 🗀					te of delive	
Ox 68' sath certiff attending or use as	igi	past 12 months?		_ive birth Pregnant at	time of dea	2 Fet	al death er <i>(Sp</i> ec <i>ify)</i>		Ectopic pre	egnanc	У	Mon	ith	Day Year
Box 68 e death certif the attending ed for use as	Physiciar	1 Yes 2 No 9 Unk	novun	Jnknown		3 <u> </u>	er (opeony)							
P.O. Box 68 s that the death certification by the attending edetached for use as		Part II. Other significant condit	ons contribu	ting to deat	h but not res	sulting in the u	nderlying ca	use giver	n in Part I.					the cause of death?
s, P.(iires that i signed d be deta	od by									_	1 Yes	2 V No	3 Pro	bably 4 Unknown
ords	Set								_		24a. Was autor	sy	prior to	utopsy findings available completion of cause of
Che law ate has	Completed							·			perfo	rmed? 2 No	death?	es 2 No
Vital Rec	Be C	25. Was case referred to medical	-				26.1		Death (Ch	eck onl	y one)			
Vit hysical this o	일	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatie		ER/Outpatient					lome 5	Residence		er: Scene
Division of Vital Records, ra dor Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should be a page 3 should be 3 should be a page 3 should be a	Certification:	27. Manner of Death 1 Natural 5 Pend	_{lina} FO	Date of Inju Month, Day,Y UND:	'ear)	28b. Time of Ir FOUND:	· · I	Injury at	t Work? 2 ✔ No	IP4	d. Describe edestrian			
Atter Atter er dear rector by th	icat	2 🗸 Accident Inves	tigation Jul	26, 2008 Place of In		1139 hrs ne, farm, stree					f. Location (Street and N	lumber or R	tural Route Number, City
Divi			not be			/ Highway	, , , .			RT	or Town, S . #197 & N	tate) Iorris Drive	, Laurel, N	I D
		20a Cartifier	nysician: To the											
To the within To the complet	Medical	29b. Signature and title of certifie	and mar	ner-stated.				cense nu						onth, Day, Year)
		111/11/	15 n	1 D			C	.C.M.E	≣.			July 27		
	-	30. ame and address o	who completed	cause of c	leath (Item 2	23a)								
R (5)		Russell Alexander MD	. Assista	nt Medic	al Exami	ner 111	Penn Str	eet, Ba	ltimore	, MD	21201			li.
Sta Registi	ate rar	31. Date filed (Month, Day Year)	Klasica	2. Registra	r's Signa dr	de la								

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician;

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Certification: To

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

6 Could not be determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLO LINE CENTER WALRENT, MA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 3 1 2008

To the Hospital

Physicia /Medic Examin	a
Funeral	
Director	
7074	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NANCY ELIZABETH WHITACRE M 08 02 2008 1736 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2**K** F 90 232-54-2804 West Virginia 06/19/1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV 1 ☐ Yes 2 ☑ No Director Morgan Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 Whitacre Road 25434 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3x Widowed 4 ☐ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Laborer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ashby Bailey ပ Lavina McDowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12911 Growdenvale Drive, N.E. Cumberland, MD 21502 Clyde R. Whitacre/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodrow Cemetery 08/05/2008 | Paw Paw, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kimble Funeral Home 188 Mosser Avenue Paw Paw, West Virginia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEFT MIDDLE CEREBRAL ARTERY STROKE ARGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MSUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D0062177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive Cumberland, Maryland 21502 Victor Crentsi 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** Benton Carl Zander /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEDICAL ATA ar If Under 24 Hrs. CENTEL CHARI 5. Social Security Number If Und 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Year) 1 ☑ M 2 □ F Months Days Hours Min. 70 281-34-3407 22, Director 1938 April Ohio Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examination count by notified at Director 1 ☐ Yes 2 X No MD St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22077 Point Lookout Road Funeral 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) President Labor Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zander William ဥ Helen Foate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Sylvia Zander (Wife) 22077 Point Lookout Road, Leonardtown, Maryland20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1 Departr ent of H 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem 8-5-2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth M01921 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo y of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause preach life. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending death. n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in the property of the pr Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi

State Registrar (Check only one)

29b. Signature and title

30. Name and ddress of Person who completed cause of death (Item 23a) (Type, Print)

SENTON, ZANDER

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Helen Altomani 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE HIGHLAND ANNE ARUNDEL Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Year) 1 □ M 2 🛛 F Months Days Hours 052-05-1295 94 Oct. 29,1913 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location MD 1 ☐Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 340 Highland Drive Apt. 102 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □XNo Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Nurse's Aide **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emanull Immusa Ontonia Coventa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Patrick Altomari/Son 7944 Queens Road Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 100918 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Years Due to (or as a consequence of): Sequentially list conditions, if any leading to inmodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☑No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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?? Is marked other than "natural", or items 23a or 28a-f shot traumatic event, I'm Medical Evar, increment by notified at

within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trailmests.

Baltimore, Maryland 21215-0036

Examine The faw requires that the death certificate be executed sician and burial-trans attending physician Physician/Medical the ase ō. signed by the sid be detached f ģ Completed has certificate this certific Be Certification: To

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in

within 2 To the I

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completely

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25. Was case in examiner?	referred to medical		26. Place of Death (Check only one)								
	2 N o	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3 🗆 DO	Other: 4 Nursing	Home 5 ■ Residence 6 □ Other (Specify)					
27. Manner of I 1 Natura 2 ☐ Accide	5 ☐ Pending investigatio	(Month, Day, Year)	28b. Time of Injury	M 28	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 □ Suicide 4 □ Homici			me, farm, street,	factory,	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a, Certifier	1 Certifying Pl	ovsician. To the best of my know	vledne death or	curred	at the time date and pla	co. and due to the cause(s) and manner as stated					

Zoa.	Certifie
	(Check only
	one)

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. JASSI 1600 CRAIN HWY SUITE 610, GLEN BURNIE, MD 21061 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 4



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:55 PM JUSTINE BLACKSTON August 12 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore 5900 Park Heights Ave. 602 Apt. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 F Days 87 06/06/1921 214-20-3006 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No **Baltimore** Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 5900 Park Heights Avenue Apt. 602 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mortuary Mortician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Wick Janie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) Joan Jarrett / Niece 5900 Park Hgts. Ave., Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 08/14/2008 Crematory 21. Signature of Funeral Service 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final fail Sepsisand DAYS disease or condition resulting in death) Due to (or as a consequence of): pheral MONTHS iscase will Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant et time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Tinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Heatth ar
Important: If item 27 Is
any injury or other trau Pages 1 and 2

Physician

/Medical

Examiner

10a. State

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Funeral

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Director

th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Eventine is ust be notified at

death v

should be filed within 72 hours after

altimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit Physician/Medical signed by the a cate has been si Completed Be

P.O. Box 68760,

of Vital Records,

Division

The law requires that the death certificate be executed certificate e Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

၉

Certification:

Medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

State

29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif

5 Pending investigation

6 ☐ Could not be

AHEndiNI

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) tug 13, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

Newland Rd M.D. 31. Date filed (Month, Day, Year) AUG 1 4 2008 . Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2008 GLADYS REDDISH BOWLING August 5:55 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heart Homes at Lutherville Lutherville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F 98 March 8, 1910 Maryland Director 213-01-8928 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1420 Front Avenue 21093 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Buyer 12 years Retail 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) William Reddish Ruth Bradley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21212 Kelly Gill Chesser (Granddaughter) 6311 Pinehurst Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 8-14-08 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland Mitchell-Wiedefeld Funeral 1 6500 York Road Baltimore,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical as attending use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 🗆 Ectopic pregnancy jo Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) forcilit 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital of 24 hours af Funeral D 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year) AUG 1 4

6701

Registrar's Signature

Charles ST.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

AMC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 August 6, 7:35 PM M Paul W. Boone /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Augsburg Lutheran Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F 212-03-8042 96 Director Sept 28, 1911 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if than "natural", or items 23a or 28a-f show MD Baltimore 1

Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road #1A Funeral 21207 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Ite Important: If tem 27 is marked other than "natural", or Ite Important of the traumatic event, the Medical Examinations. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 metallurgist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Jacob Boone Lula Wagner ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6825 Campfield Road #1A Baltimore, MD 21207 Margaret Boone/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Serie Licensee Nade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Anter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or contion resulting in death ATHEROSCHEROTTE **Physician** ARDIOVARCE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYDER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 2 No 1 ☐Yes 2 ☑ No Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MI SUITE 203 LAKFLANI 31. Date filed (Month, Day, Year) State AUG 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:17 A M August **Physician** BETTY 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □ XF 58 220-52-5817 23-49 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No 3a or 28a-f st t be notified s Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 925 N. Belnord Ave USA ms 23a must be 21205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status African Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: Š 3 ☐ Widowed ★☐ Divorced Ämerican "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education marked other than "natu matic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freddie Gregory Hattie Addison ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly R. Bradley/Daughter 4802 Hamilton Ave, 3D, Balt., MD 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/18/08 Balt.,MD Mt. Carmel Cem 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Road, Balt., MD 21206-5105 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MINUTES **Physician** espiratory /Medical Due to (or as a consequence of Examiner Imonory Disease Obstructive FUNIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed nding physician and use as the bunal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3

Ectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tes 2 🗌 No 2 1 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? Certification: 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

29c. License number -

53368

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

August 10, 2008

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** BRUCE ARTHUR Atua FRANKLIN 11:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPITAL WASHINGTON HONTGOMERY TACOMA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day 7. Age (In yrs. last birthday).

Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 10 M 2 F 249-20-136 SOUTH CAROLINA Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinational be notified at D.C. WASHINGTON, D.C. 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 4800 APITAL VSA Ant 316 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 207 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: BLACK 4 Divorced 3 Midowed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Menta! Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION FUEL TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BRUCE MADISON ODELL LULA RILLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 72 19a. Informant's Name/Relationship (Type, Print) JR (SON) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traurr once. 25715 VALLEY PARK TERRACE DAMASUUS MA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CEM. AUG. 21, 2008 BRENTWOOD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FULL, HOME 21. Signature of Funeral Service Licenses Huy a. 110 WEST SOUTH ST PREDERICE MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATORYFAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit ARDIAC that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. POXEMIA Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 T Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Handover Park way Eveenbelg Chandra Korapati 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legiple MEND ITEM#4a, b, perfhys., #10c-f, 19b, perfh, 6882, 8/26/08, WS State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#4a, perfhys, #10e, 19b, perfh, 6882, 8/28/08 0 0 8 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 12, 2008 **Physician** 8:34 AM Allen
4a Eacility Name (If not institution, give street and number)
8245 Stone Communication Burroughs August Allen /Medical 4b City, Town, or Location of Death Ellicott City 4c. County of Death **Examiner** Howard 245 Stone Crop Drive Unit Q 8. Date of Birth (Month, Day, Yea Dec. 31, If Under 1 Year | If Under 24 Hrs. ^{Year)}1950 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex. 1 □ M 2 □ F **Funeral** Hours Days Months DC 215-56-8112 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County EII icott City 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Modical Examiner must be notified at 1 ☐ Yes 2 XNo Columbia Director MD Howard 10f. Zip Code 21043 21045 10g. Citizen of What Country? 10e Street and Number **8145 8245** 8245 STone Crop Drive Unit Q U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Technician 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Arlene Frances Hoffman James Francis Burroughs 8145 Stone Crop Drive Unit Q Columbia, MD 21045 19a. Informant's Name/Relationship (Type. Print) Mrs. Mary Burroughs/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 16. 20a. Method of Disposition Aug. 1 2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 MO1357 . Paneu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC COUN CANCER MONTHS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 0 the a □Yes 2□No detached 9 ☐ Unknown 9 Unknown signed by the σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Completed certificate has been irector, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐Yes 2 KNo 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie D64395 person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST. SUITE 209 BALTIMORE MD 21204 30. Name and address of DOBERMAN, MO 37 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 4 State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:30RM **Physician** van Dennie /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give Examiner Howere Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 6.18 ay **Funeral** Days Months Hours Min. 1 XM 2□ F **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experies must be multipled at 1 Yes 2 □ No **Funeral Director** Horre 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 Heath 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Never Married 2☐ Married 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Blac ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working in DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) andsc Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 18 Be helma lames Bryant ပ Rural Route Number, City or Town, State, Zip Code) e Batto, 19b. Mailing Address (Street and Number or 19a. Informant's Name/Flelationship (Type. Print) MD 21223 Griena Johnson trede permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State .15.08 4 ☐ Donation 5 ☐ Other (Specify) lane and Address of Fallyreene Funeral Services 21. Signature of Funeral Service Licensee 5151 Barto Nati Pile Vaught U. Veese 5151 Rufo. Nat'l File L

23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ntraveron 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2**0**No 1 ☐ Yes certificate 1 □ Yes Vitál 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ↑ npatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Hospital or Attending 1.XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Sinac HOSDI 90A SYLVANUS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

heri Renee Corey	State of Maryland / Department of Certificate of Registrar		iene Reg. No. 20	08 2615
Physician/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 2220 hrs
' ral Examine	Sheri Renee Corey 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 6, 2008 4c. County of De	
	Perryman Road and Chelsea Road			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-94-6628 1 M 2 X F 32 Yrs	Months Days Hours Min.	6-3-1976	Birthplace (State or Foreign Country)
	Usual Residence of Decedent			
w any	Md. Harford Havre	e de Grace		10d. Inside City Limits 1 Yes 2 X No
viaryland 28a-f show 1 at once. ector	Md. Harford Havre	10f. Zip Code	10g. Citizen of What C	bound .
the Maryland a or 28a-f sh tiffed at once Director		21078	,	USA
with the 1s 23a se noti		as Decedent of Hispanic Origin? (Specif	fy Yes or No- 14. Race - An	nerican Indian, Black,
r death with the Maryland or items 23a or 28a-f shomust be notified at once. Funeral Director	1 Never Married 2 X Married Armed Forces? If Yes 2 X No	es, specify Cuban, Mexican, Puerto Ric	can, etc.) White, etc	:.
safter ral", o	or Dates:	Yes 2 X No specify:	Specify:	White
hours Exam		nt's Usual Occupation (Give kind of work nost of working life. DO NOT use retired)		ss/Industry
5-0036 ed within 72 hour lygiene. other than "natt ine Medical Exan		Homemaker	Н	lome
5-00 led with the M	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple	William C. Brackins		O. Wiles	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Howard M. Corey Husband	g Address (Street and Number or Rura 40 Robin Hood Ro		
and 2 and 2 fealth item 2 traun	20a. Method of Disposition 20b. Place of Disposi	sition (Name of cemetery, D	Date 20c. Location - City	
Baltimore, permit. Pages I ar Department of Hee Important: If iten injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or of		1-2008 Church	ville
altin mit. P partme portar ury or	4 Donation of Cure opecity.	Name and Address of English	imunek Funeral	
E De M	Burnaller 61			
Physician 'Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	he mode of dying, such as cardiac or re	spiratory arrest, shock, or heart	Between Onset and
≟xaminer	Immediate Cause (Final disease or condition resulting in death)			Death
	Sequentially list conditions,			
red visit	if any, leading to immediate Due to (or as a consequence of):			
Xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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60, e be execut ysician and burial - tra	UNPENDED AMENDED		224 Pate of deli	
b. Box 6876 the death certificate the death certificate by the attending phy ched for use as the the Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Female	etal death 3 Ectopic pregnancy	23d. Date of deli Month	Day Year
ox 6 ath ce	Pregnant at time of death 5 O	ther (Specify)		
D. B. tt the de by the ached f	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?
P.(,,	1 Yes 2 No 3	Probably 4 Unknown
ords, w requir s been s should 1				e autopsy findings available to completion of cause of
Records, The law require ficate has been signage 2 should be			autopsy prior death	h?
Division of Vital Records, laterated and Partending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be artification: To Be Completed	25. Was case referred to medical	26.Place of Death (Check only		103 2 110
Vital Inysician: hysician: Lilicotor, I director, To Be C	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other Nursing H	Home 5 Residence 6 🗸 O	ther: Scene
After 1 funeral	27. Manner of Death 1 Natural 5 Rending 28a. Date of Injury Aug 6, 2004 Year) 28b. Time of Aug 6, 2004 Year) 2210 hrs	- Or	Bd. Describe how injury occurred Derator bicycle auto collis	ion
Sior Attend r death ector: by the	2 🗸 Accident Investigation	1 Yes 2 V No		
Division o spital or Attending rours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		8f. Location (Street and Number of or Town, State) erryman Road and Chelsea Ro	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the edical Certification	4 Homicide 13/2021/Street 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occur			
To the Hos within 24 h To the Fur completely	2 Medical Examiner:On the basis of examination and/or investigation and manner stated.			
F S F S E	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
12	Do MINCIMO	O.C.M.E.	August 7, 200	18
(3)	Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	1 Penn Street, Baltimore, MD	21201	
State	// // / / / / / / / / / / / / / / / /	7.70		
Registra DHMH 17 Rev 1/2001	ORIGINA			
	ORIGINA	1 L		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Hettie W. Cole

/Medical Examiner

Funeral Director

show Department of Health and Mental Hygiene. Important: if items 23a or 28a-1 show important: if item 27 is marked other than 'natural', or items 23a or 28a-1 show any Injury or other traumatic event, Ire Medical Evanificat must be notified at once. Director Funeral ģ Completed Be Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

Physician /Medical Examiner

Exami

Physician/Medical

Completed

Be

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Certification:

Medical

sician and burial-transit the death certificate be executed signed by the attending physician I be detached for use as the buria The law requires that this certificate has been sral director, page 2 should Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

3. Time of Death 08 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ROSE IARE HUSPI TAL CENTER ECA /E If Under 24 Hrs. A 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 2-25-1919 Days Hours Months 1 □ M 2 🗓 F 89 241-09-9392 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 24 No Balto. Nottingham Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 3 Raylon Drive Apt. K 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ②☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 💥 ☐ No White Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Brown Charles T. McGee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4209 Cottington Rd. Nottingham, Md.2 1236 Judy C. Supper 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial ②☐ Cremation 3 ☐ Removal from State 8-13-2008 Balto. Bayview 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 BELAIR Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? JEMENTIA 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number bury H. WirsetinoT 00063327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 9000 FRANKLIN SQUARE DRIVE BALLIMURE Md. 21237 WOLDETHINGT. . Registrar's Signature

Registrar

State

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:30 P^M George L. Connolly, Jr. 08-12-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3 Glenwood Rd Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ₩ 2 □ F 212-38-1702 66 01-26-1942 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 77 is marked other than "natural"; or Items 23a or 28a-f show 77 is marked other than "natural"; or Items 23a or 28a-f show traumate event, the Medical Examiner musts be notified at 1 ☐ Yes 2√ No Director MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3 Glenwood Rd 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental Important: If item 27 is me.
any Injury or other-Be George L. Connolly Sr Ada Helen Whitford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gail Connolly (Wife) 3 Glenwood Rd Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BelAir Memorial Gar. 08-16-2008 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. lioblaston Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due o (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha perform 2 **N**o 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: neral Director; / filled in by the f within 24 hours at To the Funeral C completely filled it

> State Registrar

Medical

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifie (Check one)

29b. Signature

determined

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)
(Ny) (Nin (n.), 602 South Afword Doad # 200, Bel Arr, No 21014 32. Registrar's Signature

and manner stated.

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 13, 2008 ear **Physician** Winifred Bertha Cyphert 3:39 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist @ GBMC Towson 8. Date of Birth (Month, Day, Year) October 26, 1921 If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔀 F 216-18-4180 86 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ *** any injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2123 Lodge Farm Road 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Specify: ò 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years **Hostess** Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Hackman Ivy Winifred Hemmig ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 Lodge Farm Road, Edgemere, Maryland Dennis Wayne Cyphert son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 16, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Belair Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2008 Belair, MAryland Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk,P.A. 7110 Sollers Point Road, Dundalk,Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Cul veeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or darring Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial of Vital Records, P.O. Box 68760 Physician/Medical nding p 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Vas 2 No page 1 ☐ Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Division Hospital or Attending 1 Natural Injury 5 Pending ours after death.
neral Director: Ai 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d, Date signed (Month, Day, Year)
August 3 2008 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Balto, and Zizox 6701

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

AUG 14

Year)

2008

32. Registrar's Signature

Amend PII per ME G883 9.5.08 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lillie Aug. 8 2008 8:45 pm Μ. Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 217-26-3268 Months Days Hours 1 □ M 2 □ F Director Oct.3,1930 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Marical Experience in ast be notified at Director 1√Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with Funeral 1836 N. U.S.A. Collington Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic avant." Elementary/Secondary (0-12) College (1-4or 5+) Hospital 8th Nursing Aide HOSPI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Barnes Estelle Garnette ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 E. 36th St Baltimore, MD 21218 Tyrone Garnett/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ™Burial 2 ☐ Cremation 3 ☐ Removal from State GarrisonForestVet, CemAugl5, 2008 OwingsMills MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licenta Ind Address of Facility
IN B. SCRUGGS FUNERAL HOME
E. PRESTON ST. BALTIMORE, MD 21213 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death tosed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final uncer websbronc YUNS crease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Mo Day Year 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has performed? this certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner: 1**XX**Yes 2∏No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After Certification: 1 Natural 5 Pending investigation July 22 2008 1 ∐Yes 2 No Fall 2 Accident 9 ☐ Suicide VIKNOWN 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide N. Collington Ave, BALANNE MD Home 29a. Certifier 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signarde and title of certifier 29c. License number 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charles It torsas mo 21204 620/ n wo 32. Registrar's Simeture State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death CURTIS Onth G Day 40 AM **Physician** 2008 -DRED /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMORE 10581742 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July9, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days 1□M 2□F Director 212-24-7122 81 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ırai", or items 23a or 28a-f show Examiner must be notified at 1 TYPes 2 □ No N/A Baltimore Director MD and 2 should be filed within 72 hours after death with the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 900 White Ave. 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2√☐ No Specify. þ 3 Widowed 4 Divorced "natural" Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental LOUISE MC CULLOUGH or other traumatic Webster Fountain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Apt 8 Balto. MD 21205 1608 E. Anthony J. Curtis/Son Monument St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once, 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AUG.15,2008 KingMemorialPark BALTO, MD. Name and Address of Facility ALVIN B. SCRUGGS FUNERAL HOME 412 E. PRESTON ST. BALTO. Md re of Funeral Service Licensee 21213 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUNON week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Division or Vital Records, P,O. Box 68760, ${\mathscr G}$ resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 1100 or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 No 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2∏No investigation after death.

Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral Completely filled is Hospital 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

ALIG 1 4 2008

OSEM



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

57

PAUL PLALE

BATTROVE 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Vear PM 4a. Facility Name (If not institution, give street and number) :08 Cimarosse 08 2008 08 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death Examiner NIA Baltimore Center Baltimore VA medical If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/02/1923 5. Social Security Number 6. Sex. 1 M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 149 12 6178 85 NJ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at ATLANTIC BUFNA 1 ☐ Yes 2 ☐ No Director NJ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 HARDING HIGHWAY 08310 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN UNKNOWN UNKNOWN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE VENTURA / DAUGHTER 28 W. FOUNDRY ST., MILLVILLE, NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **VINELAND** 08/10/2008 710/2008 N.Hanover Township, N. SOL LEVINSON & BROS., INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic colon CANCEY /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 20 No Hospital: 1 Inpatient 1 ☐ Yes Other: 4 Nursing Home P 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specity) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Andleeb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Khan

Greene

10 N.

2008 32. Registrar's Signature

29c. License number

Great Street

19079

Baltimore

29d. Date signed (Month, Day, Year)

18-08 - 2008

2120

MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician August 7, 2008 8:20 PM M Colleen Thelma Danowski /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🔯 F 212-22-3358 Director 82 Feb 27, 1926 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6902 Norman Avenue 21222 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify Specify: white Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mangnes meat packing 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Eli Moore Alice Ituria Donithan 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lear/step daughter 208 Wagner Avenue Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Ropald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade, 23a. Part Lenter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Pancrea **Physician** Cancer month 3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Er ter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has be funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 □No 1 ☐ Yes 2 No spital or Attending Physician; Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 165pic & 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 14383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Ricley Hospice Baltimore MD Stand, ford np Harold 31. Date filed (Month, Day, Year) State 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For	State of Maryland				Mental Hy	giene	0 20107
		Registrar 1. Decedent's Name (First, Middle, Last)	1	Cer	tificate of	Death	2. Date of De	Reg. No. C U U	0 20101
Phys		Denise D. Culpe					Month	Day Ye	
	dical niner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	08 /	07/2008 4c. County of D	0505 A M
EXAII	illiel	Holy Cross Hosp	_ ′			Spring		Montgon	
Funer	al	5. Social Security Number 6. Sec	7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Bii	rth 9.	Birthplace (State or Foreign Country)
Directo	or	229-15-88/9	M 2 🔀 F 46	Yrs.	Incitato Bayo	Tiodio Iviiii	02/01		rgínia
land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
Mary If sh	ئ	MD Prince (Georges		La	aurel			1 XVes 2 □ No
or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th wif	ra D	11815 Randy Lai	ne			20708		U.S.A	A .
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - A Black, W	merican Indian,
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	1	□Yes 2 No	Specify:		Specify:	Black
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Maryland tal by tjene. d other than "natural", or items 23a or 28a-f show event, Ital Matical Examination in the profilial of	ed	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	pation		16b. Kind of Busine	ss/Industry
A LS	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give i life. D	kind of work done OO NOT use retired	during most of wor d)	king		•
d Z Z filed within Hygiene. other than "	Son		4	N	Medical	Billin		Privat	ce
d be file antal Hy ced oth	Be	17. Father's Name (First, Middle, Last) Glenn Culpep	ner			18. Mother's Nan Jean	ne (First, Middle Powe	, Maiden Surname) 1 1	
Maryland & 2 should be filed w h and Mental Hygie is marked other t raumatic event, to	2			401 14 111					
Dallinore, Inaryla permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any Injury or other traumatic.		19a. Informant's Name/Relationship (Type) Nehemiah Davis				Lane La		er, City or Town, Stat	
s 1 and f Health item 27 other to		20a. Method of Disposition					Date	20c. Location - City	or Town, State
Pages Tent of I		Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of ators of other place 1111 Park	08/	16/08	Lynchbur	g,VA
Dallinor permit. Pages Department of Important: If it	- Suce	21. Signature of Funeral Service License		22.	Name and Addre	ss of FacilityRO	nald Ta	aylor II	Funeral Hm
D 89F8	ä	Konald (buy/11	10	08 West	North A	Ave. Ba	altimore,	MD 21201
		23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death. se cause on each line.	Do not ente	r the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying	Severe Per	efera	l Vascu	lar Dis	ease		
Attending Physician: The law requires that the death certificate be executed rotest. Attending Physician: The law requires that the death certificate be executed rotest. Attending physician and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Ě	resulting in death) Last	Due to (or as a conseque						
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The cate h	Co						perfo	rmed? death 2 □ No 1 □ Y	1?
Iclan certifi ector,	B	25. Was case referred to medical examiner?	ospital: ספרי ויי		Tout-	26. Place of Dea	th (Check only o	nne)	
Physician: The la Physician: The la r this certificate has	F:	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 A Inpatient 2 ∐ E	R/Outpatient 28b. Time of		+ □ Nuising ⊓	-	dence 6 Other (S	pecify)
th. Afte	iţi	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	28c, Injur Work	Yes 2 □No	Zou. Describe	now injury occurred	
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talor safte	Certification:	L	building, etc.*(Specify)				City or To	vn, State)	
To the Hospital or Attending Previous after death. To the Funeral Director: After to completely filled in by the funeral	edical	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my know ler: On the basis of examinati and manner stated.	ledge, death on and/or inv	occurred at the tire estigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manned date and place, and d	r as stated. due to the cause(s)
To the vithing to the complex	M	29b. Signature and title of certifier	110		29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
		Mu,	MW		D633	43		08/07/	2008
		30. Name and address of person who cor							
		Dr. Irina Ruban	1500 Forest	Glei	n Rd. S	ilver S	pring,	MD 20910)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2 9130 am X Kene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frankford Nursing & Rehab. Ctr. Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-28-1935 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🛣 F 72 $\overset{\text{ountry})}{\mathsf{P}\mathsf{A}}$ 219-32-1498 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must he natural and once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐¥es 2 ☐ No Director MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1754 Burnham Road 21222 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ **X**¶o If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homes Cleaner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Don Palmer, Sr. Martha Gibson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Dicke, Sr. - Son 1754 Burnham Road, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Baltimore, MD 8-13-08 Bayview Crematory 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner homodia lysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 1 Yes 2 No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 250 No Other: 4 Nursing Home P 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Ye AUG 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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1	Examin	er	4a. Facility Name (If not institution, give Ruxton Health				Location of Death		4c. County	of Death $oline$	
-	Funeral		5. Social Security Number 6. Sec		n yrs. last birthday)	Dento	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		215-14-5498]M 2 X JF	86 Yrs.	Months Days Hours Min. (Mor			9, 1921	Couin Mary	yland
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	ath wi	ral	133 Sonata Way			2161			USA		- bodies
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Maryland	ould be Menta arked atic ev	To E	Justin Russell K	insey				y P. Gi			
Mar	12 shoth and hand 7 Ismutraum		19a. Informant's Name/Relationship (Ty			ng Address <i>(Street i</i> Sonata Wa					_ ′
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mo	Pages nent of int: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	-	ematory of other place		3/08	Baltimo	re.	Maryland
Baltimore,	permit. Pages : Department of the Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licens Thomas Gregor	ee	8	remation 99 Freder	Society	Of Mary			d 21228
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or								Approximate Interval Between Onset and Death
9:	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Probab	de my	ocardi	2 m /201	farc'	tion		
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	<i>f</i> o	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):						
V	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						
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O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf 1 □Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	,		23d. Date Mor	e of delive	ery Day Year
, P.O	s that the de ned by the detached	by Ph	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contr	ibute to th	ne cause of death?
ords	w requires been sign should be	ed b						10	Yes 2 No	3 ☐ Prob	ably 4 Unknown
Vital Records,		Completed						24a. Was auto perf 1□ Yes	opsy pormed2 c	rior to co leath?	psy findings available mpletion of cause of 2□ No
Vita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:		Louis	26. Place of Deat	h (Check only	one)		
o	Phys this	- To	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier		4 Inursing H		how injury occurr		v)
ion	nding l tth. r; After e funer	tion	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Y		Worl	k? Yes 2 □ No		,,		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (eet, factory, office			(Street and Number wn, State)	er or Rura	l Route Number,
	Hospi 24 hour Funer rtely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of r iner: On the basis of ex and manner stated	kamination and∕or ir	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	and due to the	cause(s) and ma , date and place,	nner as s and due to	tated. the cause(s)
	o the	Mec	29b. Signature and title of certifler	and manner stated	J.	29c. License	e number		29d. Date signed	(Month,	Day, Year)
	/				CM =	Doc	5325	55	61/2	1/2	800
_	5		30. Name and address of person who co	136 Y	Lednun	Are 8	reston	am	265	5	
44	Sta Registr		31. Date filed (Month, Day, Xear) AUG 1 4 2008	32. Registrar's	Signature						

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. **County of Death** Examiner Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours 1 0 M 2 0 F Months Days Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Exprining runsal be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes a ☐ No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates: 1 ☐ Yes Specify ≥ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) andary (0-12) College (1-4or 5+) Elementary/S 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဂ္ ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship 5 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 46 ALTO. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Box 68760, © Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but, not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 Ø No 24a. Was an autopsy performed? Yes 2⊠No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical

State

Registrar

and manner stated 29b. Signature and the of certifier

28a. Date of Injury (Month, Day, Year)

29c. License number

Injury at Work?

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 □ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1404

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

Registrar's Sign

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Marylan		artment of He <i>rtificate of E</i>			iene 2008	26171
	Physici	an	1. Decedent's Name (First, Middle, La	ist)			-	2. Date of Deat Month		3. Time of Death
,	/Media	al	Joyce Ann Foster 4a. Facility Name (If not institution, given	o street and number)		4b. City, Town, or	Logation of Dogth	August	4, 2008 Year	5:20 PM M
	Examir	ier	622 A Harborside			Jop			Harfor	
	Funeral Director		5. Social Security Number 6. S 212-46-2522	60 7. Age (In yrs. 1 60		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 19,		hplace (State or Foreign untry) nsylvania
	pue M		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	death with the Marylend rms 23a or 28a-f ehow frount to notilling at	tor	MD Harfor	4	oppa	oution.				1 ☐ Yes 2√ No
	iff the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	untry?
	s 23a		622 A Harborside		5 140 1	<u> </u>	21085		USA	
336	n 72 hours after death with the Marylen "natural", or Items 23e or 28e-f ehow palical Examiner must be notillied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2ሺ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
ָה ה	72 hor	sted	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occupa kind of work done di	tion	ing	16b. Kind of Business/	Industry
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)		,9		
7	be filed withital Hygiene. d other than		17. Father's Name (First, Middle, Last	0		homemak	er 18. Mother's Name	e (First, Middle, M	OWN home	
ב		To Be	William Duritsk					leen Hav		
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street ar			City or Town, State, 2	Zip Code)
	1 and 2 Health em 27		Robert Foster/sp		622_A	Harborsi	de Drive	Joppa,	MD 21085	
Baitimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Special	Removal from State	race or Dispos	sition (Name of natory or other place		Date 1 2	20c. Location - City or	Town, State
Rail	permit. Pege Department of Important: If eny injury or		som!	Mace	S B	Name and Address tate Anate altimore,	omy Board MD 2120	1 655 W.	Baltimore	Street
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a	n. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arre	y disew	Approximate Interval Between
,	ificate be executed g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence.						
68/6 0,	ate be nysicie he bur	edicai		d						
XOX P	death certifica e attending pt d for use as t	ician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnated 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of deli	ivery Day Year
	t the de by the a		1 Yes 2 No 9 Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				Ju, 102
coras, r	equires the	ted by Phys	Part II. Other significant conditions of		Ilting in the un	derlying cause giver	n in Part I.		accoluse contribute to	the cause of death?
Hecc	To the Hospital or Attending Physician: The law requires thet the de within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached.	Completed						24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
\ 	rician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		0	26. Place of Death		-	
ō	Phys er this eral di	٤	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA Other 28c. Injury a Work?	4 🗀 Nursing Hor		nce 6 Other (Spec	cify)
0	ath. rr: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		es 2 No		,-,	
DIVISION OF	s after de si Directo ed in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		me, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	reet and Number or Ru , State)	ral Route Number,
	in 24 hour	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my opi	o, date and place, a nion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	with To t	Σ	29b. Signature and title of certifier	+ liv		29c. License		29	od. Date signed (Month $0.8/06/2$	n, Day, Year)
				completed cause of death (Item	23a) (Type, F	om free 1	Rd. Ste	102 1	08/06/2 Bel Air, 1	40 21015
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 4 20	32. Begistrar's Signat	ure					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elton C. Flanery, Sr. 2008 August 2:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Catonsville Charlestown Care Center Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2∏ F 491-16-1216 Director 89 Oct. 26, 1918 Missouri Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County ral", or Items 23a or 28a-f show Ex-miner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane CR517 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'natural", or 1 ∐ Yes 21☑ No ģ 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter/Builder Construction is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Flanery Opal Westover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 715 Maiden Choice Lane CR517; Catonsville, MD 21228 Mary R. Flanery Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 8/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Juneral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to himmonate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequênce or Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ng physician a as the burial Certification: To Be Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ō

signed by the a d be detached for should page 2

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 5☐Other (specify)	Month Day Year
Part II. Other significant conditions		Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
		Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (Check of	nly one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 F	Residence 6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year) Injury Work?	ibe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28f. Location 28f. Location	on (Street and Number or Rural Route Number, Town, State)
29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to iminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	the cause(s) and manner as stated. me, date and place, and due to the cause(s)

To the Hospital or Attend within 24 hours after death. To the Funeral Director;

Medical

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

AUG 1 4 2008

Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Registrar

alden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician /Medical Adams PM 2240 reda 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** Baltimore The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F 79 1928 Germany Nov. 15, **Director** 513-32-2009 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ttal Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Yes 2 No notified Director Harford Aberdeen Maryland 10f. Zip-Code 10g. Citizen of What Country? the Medical Examiner must be items 23a 64 East BelAir Avenue 21001 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Completed by 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Government Civil Service 12 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and 2 should be lealth and Mental is marked Maria Christoph Joseph Wiedlich ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tran Mary Jane Monhollen (daughter) 1515 Mitchell Lane, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Gardens 8/13/08 | Aberdeen, Maryland Harford 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Fureral Service Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ardio Du Imonar minute disease or condition resulting in death) Due to (or a a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): tailure attending physician and I for use as the burial-transit law requires that the death certificate be executed pati(that initiated events Due to (or as a consequence of): resulting in death) Last ancreatic Box 68760, Physician/Medical lumor IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No the Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pe . No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has page ; 2 No 1 X Yes 2 | No 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA မ hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a TK Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) Z Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Jaszczak 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

ORIGINAL

29c. License number res 000

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 2008 **Physician** Mercy Ogoegbanam Adibe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Doctor's Community Hospital Lanham Prince Georges 8. Date of Birth (Month, Day, Year)
Dec. 30, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 1 F none 53 1954 Nigeria Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show early injury or other traumatic event, the Medical Examiner must be notified at once. Prince Georges Md. Lanham 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10220 Halton Terrace 20706 Nigeria Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 2 Married 1 □Yes 2X□No Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Associate Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Offor Josephine Okafor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest C. Adibe (Husband) 10330 Halton Terrace Lanham, Md. 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/09/2008 Lagos, Nigeria Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N. W. Washington, D.C. 20010

Approximate 21. Signature of Funeral Service Vicensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acarol /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, the fing to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examl The law requires that the death certificete be executed attending physiclan end for use es the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐XNo Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2**X** No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

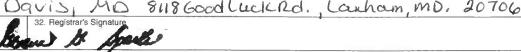
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on and manner stated 29b. Signatu of and title of certifier 29c. License number MDD 61131

P (6)

State 31. Date

31. Date filed (Month, Day, Year)
AUG 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2:32 PM Samuel Robert Baker 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 24, 1946 9. Birthplace *(State or Foreign Country)* Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 219-44-3241 61 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21742 14027 Pennsylvania Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Catherine Beaver Baker Samuel Bender Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14027 Pennsylvania Ave. Hagerstown, MD 21742 Bonnie V. Baker-wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 8-6-2008 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Multiple Viscence WE CLOSIS disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed when the conditions of the condit Due to for as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 NO 1∏Yes 2 No 1∏Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner requires that the death certificate be executed the burial-transi and P.O. Box 68760, physician use as the attending i signed by the a d be detached fo Division of Vital Records, Hospital or Attending Physician:

Examiner Physician/Medical ۵ Completed this certificate has al director, page 2 s Be မ Certification: Medical

Physician

/Medical

Examiner

Director

Funeral

Completed

Be (

Funeral Director

show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Its Madical Examinating the nothing at

d 2 should be filed within ; th and Mental Hygiene. ?7 is marked other than "r

nit. Pages 1 and 2 s partment of Health an cortant: If Item 27 is y injury or other tra

Physician

/Medical

Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

within 24 hours after deau...

To the Funeral Director: After this

3H 3 State

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month Day Yea 5 0

determined

6 ☐ Could not be

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 3 8764

August 5,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hogersbun MO 21742 P. R16615,MN Riling cill 21 Sit 127 KALL

rar's Signature 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 2008 ear 30 8:30 ам William James Byrd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 26 1A Bella Vita Ct If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 02 1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Alabama Months Days Hours 1 XM 2 ☐ F 84 Director 416-20-5124 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow r 28a-f shov notified at 1 XYes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural'; or Items 23a or ; dical Examiner must be n USA 21157 26 1A Bella Vita Ct Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 WII 1 ☐ Yes 2 🛣 No Specify: Bi-Racial þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) New York Shipping other than Elementary/Secondary (0-12) College (1-4or 5+) the Association Long Shoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F

27 Is marked ot
traumatic ever Be Wanita Johnson James Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

264 Montpelier Ct Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau. Eric Byrd/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 08/0P#2008 20c. Location - City or Town, State 1⊠ Burial 2 Cremation 3 Removal from State Garrison Forest Veterans Cem Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22 Pritts Afters of Failty Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UDCard /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page , certificate 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

WJZ 10+1VA

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2008

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			State of Maryland / D	epartment of Health and M	*	•
				epartificate of Death		/ UUB / h I / I
	•		Decedent's Name (First, Middle, Last)	Johnnoute of Bounn	Reg. No.	3. Time of Death
	Physici		Anne E. H	Boyer	July 30	y Year .
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-1/	County of Death
			Doctors Community Hospital	Lanham	i	cince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	
	Director		226-07-0958 1 M 2 XF 91 Y	3.	11/26/1916	Virginia Virginia
	yland		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	a-f s	cto	Maryland Prince George's Laurel			1 □ Yes 2 □ No X
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
	s 23a	eral	127 Yellow Spring South	20724	U.S.	
	item item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 	cify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
036	al", or	ठ्	3 ♀ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evantine must be notified at	Completed	15. Decedent's Education 16a. ((Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of workin life. DO NOT use retired)	16b. Ki	ind of Business/Industry
2	ithin ne.	nple.	Elementary/Secondary (0-12) College (1-40r 5+)		9	
12	led w Hygier her th			memaker		Home
Maryland	to per section of sect	Be	17. Father's Name (First, Middle, Last) Robert Covington	Olivia B	(First, Middle, Maiden	Surname)
IZ	should nd Me mark matic	၉		Mailing Address (Street and Number or Rura		or Town State Zin Code)
S	nd 2 saith ai			7 Yellow Spring Sout		
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evariner must be notified at		20a. Method of Disposition 20b. Place of I	crematory or other place)	ate 20c. Lo	ocation - City or Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra once.		1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ham Vet. Cem. Aug. 7	,2008 Chel	tenham, Maryland
Salt	permit. Departi Importi any Inj once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ren		
	<u></u>			9013 Annapolis Rd. L		
		4	23a Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	many Librosis	,	Orisot and Doutin
4	Examiner		Due to (or as a consequence of	: ()		
		e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	:		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate course. Enter underlying Cause (Disease or injury that initiated events c.			
Ö,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of	:		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d			
x 68	leath certificate attending physi I for use as the k	Me	IF FEMALE:			
Вох	atten for us	cian	23b. Was decedent pregnant in the past 12 months? State State 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 1 1 1 1 1 1 1 1 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	4	23d. Date of delivery Month Day Year
P.O.	w requires that the d been signed by the should be detached	Physician/Medi	1 Yes 2 Xeo 9 Unknown 9 Unknown	OLI Other (specify)		
Α,	s that gned t		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
ğ	equire en siç	Completed by	Melabolic Acidosh Acut	· Kenal Jailux.	1 ☐ Yes 2[□ No 3 □ Probably 4 ◯ Unknown
ecc	e law n has be je 2 sh	be	sepsin Hypertensino	osdiovascular Disc	4a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E	: The cate h	5	Respiratory failur Hypoxe	Puic	performed? 1 ☐ Yes 2 ☒ No	death?
Vit	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	, , ,	
of Vital Records,	Phys rthis ral dir	٦.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp. 27. Manner of Death 28a. Date of Injury 28b. Tir		ne 5 Residence (
Division	nding Ph th. : After th ! funeral	ig.	1 St Natural 5 ☐ Pending (Month, Day, Year) Inj 2 ☐ Accident investigation		od. Describe now injur	y occurred
visi	Atter	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		8f. Location (Street an	d Number or Rural Route Number,
Ö	tal or s afte al Dir	Certification:	4 Homicide building, etc. (Specify)		City or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death as a feet this certificator the Funeral Director: After this certificatompletely filled in by the funeral director.		29a. Certifier (Check only Medical Examiner: On the basis of examination and	death occurred at the time, date and place, a	and due to the cause(s)) and manner as stated.
	thin 2 the I the I	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		
	5 ≥ 6 8		250. Signature and water timer	D48213		te signed (Month, Day, Year)
	(E)	-	30. Name and address of person who completed cause of death (Item 23a) (T	una Print)		
R	19/		Neclan Ashai 4410 7415		IS MD a	20784
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		
	Registr	ar	AUG 0 1 2008 Reven 15 April			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No.

Yrs

Silver Spring

10c. City, Town or Location

7. Age (In yrs. last birthday)

75

Physician /Medical **Examiner** 1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Usual Residence of Decedent

057-26-4184

10e. Street and Number

10a. State

MD

Director

Ronald Bernstein

2. Date of Death JuMonth 29, 2008 3. Time of Death 6:50A

4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital

Montgomery

1121 University Blvd West #618

1 ★M 2 ☐ F

4b. City, Town, or Location of Death Rockville

10f. Zip Code

20902

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 1/31/1933

4c. County of Death Montgomery

Funeral

Director 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f shown items 23a or 28a-f

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Completed by Physician/Medical Examine Be Medical Certification: To

within 24 hours a

or Attending Physicien: The law requires that the deeth certificate be executed

P.O. Box 68760,

Division of Vital Records,

<u></u>	1121 University	DIAG MESC "OL	U		20702				OHI	ced .	Jean	
Be Completed by Funeral	11. Marital Status	r in U.S. 13. V		Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)			o- 14. Race - Amer Black, White					
dby	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Wes, Give Year or Dates: Ko	rean	1	□Yes 2∏No	Specify:				Specify.		White
lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decede	ent's Usual Occu ind of work done O NOT use retire	pation during most o	f working		16b. K	and of Bu	siness/	Industry
omp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	l _		neer	9a)			Fed	eral	Gov	vernment
ဝ	17. Father's Name (First, Middle, Last	")				18. Mother's	Name (F	irst, Middle	, Maider	Surnam	e)	
To B	Irving Bernstein					Anne	Wex1	er				
	19a. Informant's Name/Relationship Michael Bernstei				Address (Stree Haleswo							Zip Code)
	20a. Method of Disposition	201	. Place of	Dispos	tion (Name of atory or other pla		Date	,	20c. L	ocation -	City or	Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Themoval from State			m Garde:		/31/0	08	01n	ey, l	MD	
	21. Signature of Funeral Service Lice	nsee)			Name and Addr	,		•				
				Edw	ardı ^s as	el Fune	ral	Direc	ţion	1 Eng	n 20	1852
	23a. Part 1. Enter the Tisease, or comshock, or heart failure. List only Immediate Cause (Final	pplications that caused the de one cause on each line.	eath. Do n									Approximate Interval Betw Onset and D
	disease or condition resulting in death)	a. Stroke										
	Due to (or as a consequence of):											
	Sequentially list conditions.				<u>cular D</u>	isease						
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons									- 3	
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Ë	resulting in death) Last	Due to (or as a cons	equence o	of):							1	
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cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Mon							nth	h Day Y		
ys	9 Unknown	9 Unknown										
ā	Part II. Other significant conditions	contributing to death but not r	esulting in	the un	derlying cause g	iven in Part I.		23e. Did	tobacco	use conti	ribute to	the cause of de
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ď							_	24a. Was auto	DSV	1 1	prior to	utopsy findings a completion of ca
ပ္ပဲ								perio 1 ∐Yes	ormed? 2 🔼 N	0 1	death? I∐Yes	2 XNo
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner?											
	1 Yes 2 XNo	Hospital: 1 X Inpatient 2	☐ ER/Ou	tpatient	3 DOA O	her: 4 🗌 Nurs	ing Home	5 ☐ Res	idence	6 □Oth	er (Spe	cify)
Ë	27. Manner of Death	28b. T				280	28d. Describe how injury occurred					
엹	Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year	′ "	ıjai y		nkr ⊡Yes 2. ∐No	,					
fice	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - A	t home, fai	m, stre	et, factory, office		28f	Location (Street a	nd Numb	er or R	ural Route Numb
erti	4 Homicide determined	building, etc. (Spe	ecity)					City or To	wn, Stat	e)		
Medical Certification: To	29a. Certifier 1 Certifying P	hysician: To the best of my l	knowledae	, death	occurred at the	time, date and	place, an	d due to the	e cause/	s) and ma	anner a	s stated
dic		miner: On the basis of exam and manner stated.	ination an	d/or inv	estigation, in my	opinion, death	occurred	at the time	, date ar	nd place,	and due	e to the cause(s)
Me	29h Signature and title of certifier		1		29c Licer	nse number			29d D	ate signe	1 (Mont	th, Day, Year)
	Deso she	4. Hagger	t41	10	D324				Ju1	y 29	, 20	008
			,									

1 ▼ Yes 2 No 10g. Citizen of What Country?

10d. Inside City Limits

Approximate Interval Between Onset and Death

Birthplace (State or Foreign NY intry)

United States

Day Year

use contribute to the cause of death? □ No 3 □ Probably 4 □ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Haggerty MD 9707 Medical Center Drive Rockville MD 20850

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician The 1 ma 2008 Carrol1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAISbury
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Peninsula Ked and Medice Wicomico Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F Yrs Director 412-24-9870 9-25-1914 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Maple Way 21804 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No ģ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace ပ Wilson Millie Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Carroll - Son 215 Maple Way, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Springhill Mem. Gds. 7-31-2008 | Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Herry 1705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ KIDNEY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be

Physician /Medical Examiner

28a-f show

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or items 23a

is marked other than

permit. Pages 1 and 2 should be filk Department of Health and Mental H, Important; If Item 27 is marked oth any Injury or other traumattc even

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Records,

Division of Vital

event, the Medical Examiner must be notified at

the death certificate be executed burial-trai attending ģ the þ page 2 should has certificate Hospital or Attending Physician: this

Certification: To

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	spital: 1 🔼 Inpatient 2		3 □ DOA	Other: 4 \sum Nursing H	lome 5 Res	idence 6	i □Other (Specify)
	28a. Date of Injury (Month, Day, Year)	a. Date of Injury (Month, Day, Year) 28b. Time of Injury		Injury at Work?	28d. Describe		

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

00062916

(Check only one) 29b. Signature and title of certifier

1 Yes 2 No

4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) JULY

SOUTH DIVISION SUITE & SAZISBURY MOZIQUE 1415 GUTTERREZ SVETZANA

31. Date filed (Month, Day, Year) JUL 2 9 2008 State Registrar



24 hours after death Funeral Director;

within 2.

Medical

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29ª **Physician** July 2008 Agnes Clements Irene 5:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Co. Nursing & Rehab. La Plata Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 204 Yrs. Director 219-58-8035 Usuel Residence of Decedent Apr.18,1907 Maryland filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at 1X Yes 2 □ No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Road 20646 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes A No Specify: Specify. 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy important: if item 27 is marked oth any linky or other treumstic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Simms Pauline Shorter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Clements/Son 14865 KING CHARLES DR. ISSUE, MD. 20645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 1, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State St.Mary s Ch.Cem. Charlotte Hall, MD 4 Donation 5 ☐ Other (Specify) 2008 22. Dame and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Fureral Service Licensee ¥100479 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physicien and deteched for use as the burial-transit The law requires that the death certificate be executed OIA Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ å 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 1 XNatural 2 Accident Injury 5 Pending within 24 hours after death, To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0061652 2008 30. Name and a ed cardse of death (Item 23a) (Type, Print) Postoffice Rd MD 0600 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 AUG

DHMH 17 Rev 1/2001

Registrar

paragram.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July **Physician** 2^{Day} Carolyn Deputy 2008 10:10 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Casey House - Montgomery County Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 X F 220-56-5526 56 Director Oct. 18,1951 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Anna Court 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4or 5+) than filed withir Hygiene. 12 should be filed wi h and Mental Hygien 7 is marked other th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Edward Graham ည Maleita Sutphin traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a Item 27 i Robert Deputy/Husband 40 Anna Court, Gaithersburg, MD 20877 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any Injury or ott 1 🗆 Burial 2 🔟 Cremation 3 🗀 Removal from State July₈29 4 Donation 5 Dother (Specify) Alexandria, Virginia 22. Name and Address of Facility
Devol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee IRAcy A STUVER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Chordoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (biosass or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Year Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Ö 9 ☐ Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 : autopsy performed' certificate 1 Yes 2 X No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2XNo Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ Other (Specify) $_{6}$ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 XNatural 5 Pending investigation Within 24 hours after death.

To the Funeral Director: Aft M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check of one) the

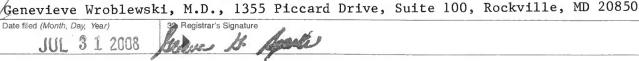
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

rese

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

July 28, 2008

	1	State of Mary	land / Depa <i>Cer</i>	rtment of Hertificate of L	ealth and l Death	Mental Hy	giene Reg. No. 20	08 26182
Physician		1. Decedent's Name (First, Middle, Last)	sham			2. Date of De Month		3. Time of Death
/Medical Examiner		4a. Facility Name (If not institution, give street and number) CDASTALHOSPICR AT The La	he	4b. City, Town, or SALISIS			4c. County	
Funeral Director			n yrs. last birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	9. Birthplace (State or Foreign Country) Maryland
aryland show			c. City, Town or Lo					10d. Inside City Limits 1 ★Yes 2 No
ifter death with the Main ritems 23a or 28a-f sininer must be notified Finneral Director	2	Maryland Wicomico 10e. Street and Number 108 Autumn Lane	Fruitlan	10f. Zip Code 21826		:	10g. Citizen of W	What Country?
be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Bo Completed by Euraria Director	y i dilcia	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:	'	Mas Decedent of Hi f Yes, specify Cuba l □ Yes 2 🕱 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Blac	e - American Indian, k, White, etc. white
ed within 72 hour ygiene. Per than "natural t, the Medical E)	in bicien r	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	dent's Usual Occupa kind of work done o OO NOT use retired	luring most of wo	rking		usiness/Industry
12 should be filed within in and Mental Hygiene. T Is marked other than "raumatic event, the Mec	5	12 –	owne	r		me (First, Middle	Maiden Surnam	sales
should the marked marked marked marked marked		James Kirwan 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a		y Bennet		State, Zip Code)
		Otis G. Esham, Jr/husband	108 20b. Place of Dispo	Autumn L	ane, Fr	uitland,		City or Town, State
Pages 1 nent of F nt; If Ite iry or ot		1 Burial 2 XCremation 3 Removal from State	Salisbury	natory or other plac	i .	8/08		bury, MD
permit. Pages 1 and Department of Heal Important: if item 2 any Injury or other once.		21. Signature of Funerat Service Licensee	22	2. Name and Address Holloway 501 Snow	ss of Facility Funeral Hill Rd	., Salis	bury, MI	nal Association 0 21804
Physician		23a. Part Enter the disease, or complication that cau d her k, or heart failure. List only one cause on ear lin- Immediate Cause (Final disease or condition resultino in death) a. MRT 5	e death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
/Medical Examiner		Due to (**- a c	onsequence of):				25-118-11	
executed in and ial-transit	aume	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decade of Figury that initiated events cause.						
icate be executed physician and sthe burial-transit	alcal Ex	resulting in death) Last Due to (or as a c	onsequence of):					
ath certif ttending or use as	Physician/met	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			ate of delivery onth Day Year
signed by the a	2	Part II. Other significant conditions contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.		tobacco use cont	tribute to the cause of death? 3 Probably 4 Unknown
sician: The law requires to certificate has been signe rector, page 2 should be	Completed					24a. Was auto perf 1 Yes	psy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ ₩6
hysician: The lavithis certificate has all director, page 2	g	25. Was case referred to medical examiner?		nt 3□ DOA Oth	er.	eath (Check only	one)	
nding Physith.	ation: 10	27. Manner of Death Natural 5 Pending Accident investigation 1 Propatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury	of 28c. Injur	4 Li Nursing	Home 5 ☐ Res 28d. Describe	idence 6 ∐Oth how injury occur	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc. ((Specify)			City or To	wn, State)	ber or Rural Route Number,
e Hosp 124 hou e Funei letely fil	Medical	29a. Certifier (Check only one) A Certifying Physician: To the best of examiner: On the basis of examiner and manner state	xamination and/or in	nvestigation, in my o	pinion, death oc	curred at the time	, date and place,	and due to the cause(s)
To th within comp	Me	29b. Signature and title of certifier	0	29c. Licens	e number 05840	0	29d. Date signe	Bury up 218
on		30. Name and a was of person who completed cause of dea GHUAM WARLS COASTA	th (Item 23a) (Type	Print) P.	OBOX	1733	SAUG	Bury up 218
Stat Registra		31. Date filed (Month, Day, Year) 32. egistrar's	s Signature	forts				/

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William **Physician** Hamilton Everitts 11 ISAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown, Washington If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral X**□ M 2□ F Months Days Hours Min. 215-26-8632 78 6-6-1930 Director Big Pool, MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. Count mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan partment of Health and Mental Hygiene. ordants: If item 27 is marked other than "natural", or items 23a or 28a-f show ordant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatte event, it is Macical Example and injury or other traumatte event, it is Macical Example at the confined at 10d. Inside City Limits MD Washington Big Pool Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10977 Big Pool Road 21711 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married _{Speci}white Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade Truck Mfq.Co College (1-4or 5+) Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Hamilton Everitt Mary Louise Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10977 Big Pool Rd. Big Pool, MD 21711 Carolyn R. Everitts permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Orchard Ridge Cem 20a. Method of Disposition Aug.5, 20c. Location - City or Town, State tv☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hancock, 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Payl 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0 the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate | 2 No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. heral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d determined 4 ☐ Homicide Preftfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 50 X D0063233 rson who completed cause of death (Item 23a) (Type, Print) 5 Shahid Mahmood, 580 Northern Ave., Hagerstown, MD MD 21742 31. Date filed (Month Year) istrar's Signatur State AUG 04 2008 Registrar

			For State Registrar	State	of Maryla		artment of I		and M	lental Hy	giene Rag. No.	308	26184
			1. Decedent's Name (First, Middle	e, Last)						2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		Billy Junior	Franklin						July	29	2008	5:50 P ^M
	Examir		4a. Facility Name (If not institution	n, give street and n	um <i>ber)</i>		4b. City, Town,	or Location o	of Death		4c. Cou	inty of Death	
			Harford Memor	rial Hosp	ital		Havre d					larford	
	Funeral		5. Social Security Number	6. Sex 1 ፟ M 2 ☐ F	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birthp	lace (State or Foreign htry)
	Director		241-54-3377			71 Yrs.		11		June 1	12, 193	Nor	th Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
	Manyl f sho	5	Warral and 1 Care										1 ☐ Yes 2 🛣 No
	h the Marylan rr 28a-f show	Director	Maryland Cec 10e. Street and Number	11		Conowin	10f. Zip Code				10g. Citizen	of What Cour	ntry?
	With With	0	795 Bell Mano	r Rd.			219	18			USA	A	
_	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show than Modical Examinar must be notified at	Funeral	11. Marital Status	12. Was De	pedent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cub		gin? (Spe	cify Yes or N		Race - Americ	
0 %	after a	큔	1 ☐ Never Married 2 💢 Marr	ied 1 ☐ Yes	2 (XNo				i, Puerto	Hican, etc.)		Black, White,	_
3 D	ours a	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 📉 No	Specify:			Spe	ecity: Wh:	rte
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6	s 1 and of Health Itam 27 other tr		Patsy Frankli 20a. Method of Disposition	n/Wife	20h		Box 191 osition (Name of	Cono		O, MD	21918	on - City or To	own State
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Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of Fundal Service	/ WI	7/4		2. Name and Addr R.T. Foa	ard Fu	nera	1 Home	, P.A.		
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	-12	patic	Coa	na					
(00.	Examiner			Due to	(or as a conse	tuence of):	100						
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S X	th cer tendir r use	an/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		□Ectopic pregnanc	CV			23d.	Date of deliv	
> .	requires that the death certifica een signed by the ettending ph nould be detached for use as th	ਹ	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specify)					Month	Day Year
P.0	that the d ed by the detached	Physi	9 Unknown	_1						00.00			
7 '5	uires tha signed I d be det	è.	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	underlying cause g	iven in Part I.					he cause of death?
7 2	w requi	Completed								1	Yes 2□N	o 3 ☐ Prot	Sabiy 4 Cariknown
\$ T	2 8 8	n pe								24a. Wa auto	s an 2	4b. Were auto	ppsy finding available impletion of cause of
(T		ő									ormed? 2 ☑ No	death? 1 ☐ Yes	2 1 No
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medica examiner?				10		of Death	Check only	onel		
3 5	Physician: this certific ral director,	은	1 Yes 2 140	1	Impatient 2		III 3 DOA				sidence 6 🗆		(y)
7 5	of the state of th	i.	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	9	e of Injury onth, Day Year)	28b. Time of Injury	We			28d. Describe	how injury oc	ccurred	
Jily	Attanding r death.	cat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be		<u> </u>		Yes 2 🗆		004	/C+4 N		10-11
逢喜	or Al	Certification:	4 Homicide determ	nined 286. Plac buil	ding, etc. (Spec	nome, tarm, st	treet, factory, office)			(Street and N own, State)	umber or Huri	al Route Number,
12	ours caraf	2	29a. Certifier 1 Vertifyii	ng Physician: To th	ne hest of my ki	nowledge deal	th occurred at the I	ime date an	d place	and due to the	a caucale) and	d manner as s	hatet
-	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi	edicai	(Check only 2 Medical one)	Examiner: On the	basis of examir	nation and/or in	rvestigation, in my	opinion, dea	th occurr	ed at the time	, date and pla	ice, and due t	o the cause(s)
	To the within To the complete	₹	29b. Signature and title of certifie	r A			29c. Licer	se number			29d. Date si	gned (Month,	Day, Year)
	F > F 0		•	XNUV)		1	1202	15		7	30/08	Y
	5		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type	, Print)						
			KNOIRM	0,601	S. Ur	non a	ve, Ita	2 1/100	lega	ace 1	nd 2	1078	
	Sta		31. Date filed (Month, Day, Year,	2008	Registrar's Sig	nature	160	1 1 1 1	-				
	Regist	ar	AUG 12	JUO TILA	The D	1470	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2008 30 3:00 Frank, Jr. 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death 9002 Harris Street Frederick Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Social Security Number Date of Birth (Month, Day, Year) Months Days 1⊠M 2□F 193-32-1084 65 26, 1942 Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9002 Harris Street 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Controller Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer A. Frank Marguerite Klein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Frank / Wife 9002 Harris Street Frederick, Maryland 21704

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. **Physician** /Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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Examiner

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

the burial-tran ed by the a detached f To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

Stauffer Crematory August 4 Donation 5 Other (Specify) Stauffer Crematory 2008 Frederick, Maryland	1	OO Mathed of Dissessition	20h [Place of Disposition (A	lama of	Date	1 200	continu City or	Town Ctate	
21. Signature of funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Approximate Immediate Cause (Final death) 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death 25a. Part1. Enter the disease, or completion of cause of death 25a. Part1. Enter the disease, or completion of cause of death 25a. Part1. Enter the disease, or completion of cause of death 25a. Part1. Enter the disease, or completion of cause of death 25a. Date of delivery Month Day Year 25a. Did tobacco use contribute to the cause of death 25a. Was case referred to medical 25a. Was an autopsy performed? 25a. Was an autopsy performed? 25a. Was case referred to medical 25a. Was case referred to medical 25a. Was an autopsy performed? 25a. Was case referred to medical		·	/	cemetery, crematory o	r other place)			Location - City of	TOWN, State	
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40 25. Was case referred to medical companies 26. Place of Death (Check only one)	>	Part II. Other significant conditions conti	ibuting to death but not res	sulting in the underlying	g cause given in Par	t I.	23e. Did tobacco	use contribute to	o the cause of death?	!
40 25. Was case referred to medical companies 26. Place of Death (Check only one)	9	Cancer C	aclexie	. 4			1 Tes	2 □ No 3 □ P	robably 4 ⊡Uπkno	wn
40 25. Was case referred to medical companies 26. Place of Death (Check only one)	te	- Ca			_			1		
40 25. Was case referred to medical companies 26. Place of Death (Check only one)	를							24b. Were a	utopsy findings availa	uble
40 25. Was case referred to medical companies 26. Place of Death (Check only one)	E						performed?	death?	•	,
25. Was case referred to medical 26. Place of Death (Check only one)	ŏ							lo 1 Li Yes	3 2 LI NO	
	Be	examiner?	20.1			ce of Death (CI	heck only one)			
1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		1 ☐ Yes 2 🔀 No	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 🗆 1	Nursing Home	5 🛛 Residence	6 □Other (Spe	ecify)	
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	-	27. Manner of Death			28c. Injury at	28d.	Describe how inj	ury occurred		
1 Natural 5 Pending (Month, Day Year) Injury Work?	ō		(Month, Day Year)	1 , ,		¬No				
2 Accident Investigation Inves	cat	Z L Accident		100 1000						
Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	É	determined	28e. Place of injury - At he building, etc. (Speci	ome, farm, street, fact fv)	ory, office	28f.			ural Route Number,	
	e L		, (- <i>p</i>	**		1	-1, -1 1 1 111, 510			
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	0	29a Certifier 1 🕅 Certifying Physic	cian: To the hest of my kno	owledge, death occurr	ed at the time date	and place, and	due to the cause	(s) and manner a	s stated	
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	S	(Check only 2 Medical Examine	er: On the basis of examina							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	ed		and manner stated.							
200,000,000,000,000,000,000,000,000,000	Σ	1 1 1 1		_	29c. License number	r / , /	29d. E	ate signed (Mon	th, Day, Year)	
1) WA-2 HEGATIND 1044184 1 7-30-8		1 × 14-2 H	ECTTTIV	(I)	D441	84		7-30	0-0	

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State Registrar B

31. Date filed (Month, Day, Year)

Drue

21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

homas

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32. Registrar's Signature

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State	of Maryland	/ Department of	of Health and	Mental Hygi	ene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 20:50 TANE FRALEY JULY 28 2008 M. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Homewood Health Care Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days Hours Min. 219-05-8038 88 Yrs. Director Maryland May Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State worke the Medical Examiner must be notified at 1 Yes 2 No Frederick Frederick Funeral Director LPM. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 #249 United States 7407 Willow Road 238 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Be Completed by 3 ₩Widowed 4 Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Dwyer Marshall George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Box 87, New London, Pennsylvania Sherrill F. Jones / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/08 Laytonsville, Md. 4 □ Donation 5 □ Other (Specify) Laytonsville Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home muriel N. 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 18A1 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quá to for se a consequence of) Examiner sicien and e burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 Probably 4 Unknown 2 NO 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 X No 1 ☐ Yes Division of Vital 25. Was case referred to medica examiner? Be 26. Place of Death | Check only one Hospital: Other: 1 Yes 2000 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA ▲ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hosp.
within 24 hours ette
the Funerel D' filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29/08 40 D 16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 300 West 9th Street, Frederick, Md. Casper Cline, M.D. 31. Date filed (Month, Day, Year) 32. Registra/s Signature State Registrar

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Division or Vital Records, P.O. Box 68760,

Reg

	T = State Registrar	Cer	tificate of l	Death	Reg	J. No.	20101
	Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
cian	Natalie Judith Fleming				July 29	Day 2008 Year	5:23 p м
dical niner	4a. Facility Name (If not institution, give street and number) 2324 Southfield Court		4b. City, Town, or Finks	Location of Death		4c. County of Deat	
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
ai or	220-94-2996 ^{1□M 2} XF	42 Yrs.	Months Days	Hours Min.	8. Date of Birth Apr 7,	966 Mai	yland
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
ctor	Maryland Carroll			Finksburg	9		1 □ Yes 2 No
al Director	10e. Street and Number 2324 Southfield Court		10f. Zip Code	21048	100	g. Citizen of What Co USA	untry?
Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
	Armed Forces? 1 Never Married 2 Married 1 Yes 2 M 3 Widowed 4 Divorced Year or Dates:	No .	1 Yes, specily Cuba 1 ☐ Yes 2 No	Specify:	rican, etc.)	Black, White Specify: W	e, etc. nite
eg	15. Decedent's Education	16a. Deced	tent's Usual Occup	ation	. 10	6b. Kind of Business/	Industry
Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		kind of work done of NOT use retired Omemaker	during most of work i)	ing	Own Home	Э
Be	17. Father's Name (First, Middle, Last) John A. Goetz	l			e (First, Middle, Mi ella Jone		
은							
	19a. Informant's Name/Relationship (Type. Print) Steven P. Fleming, husband					City or Town, State, 2 rg, MD 210	
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo Souting creat Carroll (Oc. Location - City or Winfield,	
-	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		_		1	oraw Funer	
ouce	Musta R. + Sulva	9	1 Willis	Street,	Westminst	er, MD 21	
	23a. Part1 Enter the disease, or complications that caused shows, or heart failure. List only one cause on each li	the death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
n				Cance			Onset and Death
al	resulting in death)	a consequence of):	o I cas,	Carne			444 DWG
r		,					
ē E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):					
直	Cause (Disease or injury						
Exa		a consequence of):					
/Medical Examiner	d						
edi						- 12	
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	livery Day Year
hys	9 Unknown 9 Unknown				4		
	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba		the cause of death? robably 4 □Unknown
ete					24a. Was an	24h Were a	utoney findings available
Completed by					autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?				th (Check only one)	
은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie			4 □ Nursing Ho		nce 6 □Other (Spe	ecify)
ation:	27. Manner of Death 28a. Date of Injunction 28a. Date of Injunction 2 Accident 28a. Date of Injunction (Month, Date of Injunction 18a.	ury 28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe how	v injury occurred	
Medical Certification:		ury - At home, farm, str c. (Specify)	eet, factory, office	-	28f. Location (Stree City or Town,	eet and Number or R State)	ural Route Number,
lical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) (Check only one) Medical Examiner: On the basis of and manner stand manner s	of examination and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
Mec	29b. Signature and title of certifier	atou.	29c. Licens	e number	29	d. Date signed (Mon.	th, Day, Year)
	Mulnohk Chota	m	03	36986	7	July 30	12008
	30. Name and address of person who completed cause of a			adway	Balt	Mare A	10 21231
State	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	1	actioning	54.7		Nie of
strar	JUL 3 1 2008 🕊	due to	Acort a				

				Type or Pri							_	
		For Ame	nd 23a pe	State of Mer phys. m	aryland £882 8	I/Depa B/I4/Cer	ertment of I	lealth and N Death	Mental Hy	giene ,	2008	3 25188
on de	20		ne (First, Middle, Las						2. Date of De		Year	3. Time of Death
Physic /Med		MABEI	L LUCILE	FOX						26,2		0305 ™
Exami		4a. Facility Name (/	If not institution, give	e street and number))		4b. City, Town,	or Location of Death	1	4c. C	ounty of Deat	th
		SOUTHER 5. Social Security N		SP.CENTI	ER ge (In yrs. Ia	et hirthday)	CLI If Under 1 Year	NTON If Under 24 Hrs.	8. Date of Bi			SEORGES thplace (State or Foreign
Funeral Director		226-54-		M 2√F		8 Yrs.	Months Days		(Month, Di	ay, Year) - 1940	VIF	COUNTY)
σ		Usual Residence of	f Decedent					1 1				
arylar show d at	_	10a, State	10b. County	T.C	10c. City,	Town or Lo		D.E.				10d. Inside City Limits 1 □ Yes 2 No
he M 28a-f otifle	ecto	MD .	CHARI	TEO .			WALDO	Kr		10- 00-	n of What Co	
with Ba or	Funeral Director			HINGTON H	ROAD			602		U.S.		outiny:
death ms 2;	nera	11. Marital Status		12. Was Decedent	Ever in U.S	. 13.		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No		. Race - Ame	
after or Ite	F.	_	ried 2 ☐ Mamied	Armed Forces 1 Yes 25 If Yes, Give Year or Dates:	No		1 ⊡Yes 2.52/No		o Alcan, etc.)		Black, Whit	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 ▼ Widowed		L			dent's Usual Occu					
in 72 "nal	Completed		15. Decedent's Ed	ade completed)		(Give		during most of wor	king	160. Kinu	of Business/	industry
d with giene. ir than	l Wo	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	300	KKEEPER			GAS	STATI	ON
al Hyg t othe	Be		(First, Middle, Last,)				18. Mother's Nam	ne (First, Middle	e, Maiden Se	urname)	
ould b Ment arkec	2		RD SPROU					VIRGIN				
12sh hand 7ism traum			lame/Relationship (t and Number or Ru				
1 and Healt tem 2		20a. Method of Dis	N FOX-SC	DIN	20b. Pla	ace of Dispo	sition (Name of	ASH.RD.	Date		tion - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		1 DBurial 2		Removal from State	ce	metery, crei	matory or other pla	ace) ; RDENS 8-	-1-08		ORF,	
mit. F partm sortar / inju			uneral Service Licer	**	479 (22	2. Name and Addr	ess of Facility FUNERAL	CEDV	Į.		
permi Depa Impo any ir		Mu	hal	The			LA PLAT	A, MD. 20	3646	ICE, F	· A .	
Physician	_	Immediate Cause disease or condition	(Final	pplications that cause one cause on each	torial	Taru	er the mode of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	s a conseque	ence of:	ernia rep	oair				
uted I Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	mmediate erlying r injury	Due to (or as	s a conseque	ence of):						
e executed ian and urial-transit		resulting in death)	Last	CDue to (or as	s a conseque	ence of):						
icate be exphysician by the buria	Physician/Medical			d								
ding p	/Mec	IF FEMALE:		23c. If yes, outcome	o of prognas	101/						
atten	cian	23b. Was deceder in the past 12	2 months?	1□Live birth	2 Fetal	death 3[☐Ectopic pregnand☐Other (specify) _	су		23	d. Date of de Month	livery Day Year
the d by the ached	hysi	1 ☐ Yes 2 9 ☐ Unknown		9□Unknown				-				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	by	Part II. Other signi	ificant conditions	contributing to death	but not resul	ting in the u	nderlying caus <i>e</i> gi	iven in Part I.		tobacco use		o the cause of death?
aw rec s beer	lete								24a. Was	s an	24b. Were a	utopsy findings available
The la	Completed									opsy formed? 22 No	prior to death? 1 ☐ Yes	completion of cause of s 2 □ No
clan: ertifica	Be C	25. Was case refe examiner?	rred to medical					26. Place of Dea				
chysic this o	2	1 ☐ Yes 2	No	Hospital: 1 Inpat		R/Outpatier	IL 3 DOA		ome 5□Res			ecity)
ding I	ion:	27. Manner of Dea	5 □ Pending investigation	28a. Date of Inj (Month, D	ay Year)	28b. Time o injury	Wo	ury at ork?]Yes 2 □ No	28d. Describe	how injury	occurred	
Attender death	fical	2 Accident 3 Suicide	6 ☐ Could not be	e 28e. Place of in	njury - At hor	ne, farm, str	eet, factory, office				Number or R	ural Route Number,
al or safter	Certification:	4 ☐ Homicide		building, e	etc." (Specify))			City or To	own, State)		
e Hospil 124 hour e Funer letely fills	Medical (29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exa	hysician: To the bes mine: On the basis and manners	of examinati	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) a e, date and p	and manner a place, and du	s stated. e to the cause(s)
To th withir To th	Me	29b. Signature and	tine of certifies	2			29c. Licen	se number		29d. Date	signed (Mon	th, Day, Year)
		4	4			>	D28	8639		7-2	6-68	Ó
		30. Name and add	lress of person who	completed cause of	death (Item	23a) (Type,	Print)					
	tate	Jacque	s Zephi	rin 7501 3 2008	Surr tre's Signatu	atts	Rd. Su	ite 303	Clint	on, A	4D_20	735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate of De	eath	intai i iygic			108 591
Physic dical Exan	cian nine	Decedent's Name (First, Middle,Last)		ffin, Jr.			te of Death		3. Time of Death
		4a. Facility Name (if not institution, give street and numbe			ity, Town, or Location	Jul of Death	onth ly 25, 20	08	1732 hrs
		33247 Melson Rd.			elmar	TOI Death		4c. County of D. Wicomico	eath
Funera Directo			ge (In yrs. I	<u>-</u>		der 24Hrs. 8. E	ate of Birth	(MM/DD/YYYY) g.	Birthplace (State or
Directo		215-72-2919 1XM 2F	50	Yrs.	onths Days Hour	's Min.	4/07/	Fo	reign faryland
any		Usual Residence of Decedent 10a. State 10b. County	10a City	Town or Location			-7 - 0 - 7	1000 11	
*		Maryland Wicomics		Delmar					10d. Inside City Limits
Maryland 28a-f show 4 at once.	Director	10e. Street and Number			Zip Code		- 1.0		1 Yes 2 X No
the M a or 2	ia			101	21875		100	g. Citizen of What C	country?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Mantal Status 12. Was Deceden			edent of Hispanic On	gin? (Specify)	es or No-	USA	nencan Indian, Black,
r deat or ite	E	1 Never Married 2 X Married Armed Forces	? No	If Yes, s	pecify Cuban, Mexica	n, Puerto Rican	, etc.)	White, et	C.
rs afte ural",	۾	3 Widowed 4 Divorced If Yes, Give Year or Dates:	rmy		2 X No specify			Specify: wh	ite
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or		16a. Decedent's Us during most of	ual Occupation (Give working life. DO NOT	kind of work do use retired)	ne	16b. Kind of Busine	ss/Industry
5-0036 led within 72 llygiene. other than the Me lical	lam	12 –	J.,	mainten				Dlymouth	Tube Co.
15-0 ited w Hygie 1 othe						r's Name (First,	Middle, Ma	r Tymouch	Tube Co.
21215-0036 wild be filed within 72 Mental Hygiene. marked other than	Be C	William Hayward Griffin, 19a. Informant's Name/Relationship (Type, Print)	Sr.			ni Yvonr			
9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. Fient 27 is marked other than "natural", or items 23a or 28a-f she rraumatic event, the Markal Laminer must be notified at once.	ို	Marsha Lynn Griffin/wife		19b. Mailing Addr	ess (Street and Num	nber or Rural Ro	oute Numbe	er, City or Town, St	ate, Zip Code)
ore, N es l and of Healtl If item		20a. Method of Disposition	20b. P	Place of Disposition (I	Melson Rd.	Date Date		20c. Location - City	or Town State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr.		1 X Burial 2 Cremation 3 Removal from St 4 Donation 5 Other Specify:	ate C	rematory or other pla	ce)			LOO. LOCATION - Gity	or rown, State
alti rmit. spartm sports		21 Stopature of Funeral Service Licensee	Plt	tsville (Cemetery nd Address of Facility	7/30/0	8	_Pittsvi]	le, MD
_ =====	0 1	David H. Compron	CFSf	501 HOLL	oway Funer Snow Hill	al Home	Prof	fessional	Association
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter the mod	e of dying, such as ca	ardiac or respira	atory arrest	, shock, or heart	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death)	Cardiova	ascular Disease					Between Onset and Death
		or condition resulting in death) Due to (or as a conse	quence of)	:					
	iner	if any, leading to immediate Due to (or as a conse	quence of)	:					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	quence of)	:					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d							
O, be ex sician	/Medical								
8760, lificate be		IF FEMALE: 23b. Was decedent pregnant in the	e of pregna	ancy				23d. Date of delive	ry
Box 68 e death certi the attendin ed for use a	sicial	past 12 months?	ime of deat	2 Fetal deat	-	pregnancy	11	Month	Day Year
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ires that the de signed by the	by F	Part II. Other significant conditions contributing to death	but not res	ulting in the underlying	ng cause given in Par	t I. 23e	. Did tobac		the cause of death?
ds, quires sen sig	fed					_ [1	Yes 2	2 No 3 Pro	obably 4 🗸 Unknown
COL law re has be	Completed					24a	. Was an autopsy	prior to	utopsy findings available completion of cause of
tal Reco		05.00				1	performed Yes 2 ✔	d? death?	es 2 No
of Vital Physician: er this certifi rral director,	Be	25. Was case referred to medical examiner?			26.Place of Death (C	check only one)			
1 of Vital Records, fing Physician: The law require After this certificate has been si funeral director, page 2 should b	٦ ا	1 ✓ Yes 2 No Inpatien 27. Manner of Death 28a. Date of Injur		R/Outpatient 3	DOA Other 4 28c. Injury at Work?	Nursing Home		sidence 6 🗸 Othe	er: Scene
- = - ^ ≥	ţio	1 Natural 5 Pending (Month, Day,Ye	ır)		1 Yes 2 N	I	scribe now	injury occurred	
Division pital or Attendir ours after death, teral Director: A	ertification:		ry - At hom	e, farm, street, factor			ation (Stree	et and Number or Ri	ural Route Number, City
id sp	() F	4 Homicide determined (Specify)				or T	own, State)	are reduce reamber, city
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my one)	(nowledge,	death occurred at th	e time, date and place	e, and due to th	e cause(s)	and manner as stat	ed.
To the within To the comple	Med	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and fittle of certifier	iation and/	or investigation, in m	y opinion, death occu	rred at the time	, date and	place, and due to th	e cause(s)
du	-	11/ 2 1/11		29	c.License number			d. Date signed (Mo	nth, Day, Year)
Adr		30. Name and address of person who completed cause of dea	th (ltc= cc		O.C.M.E.		Ju	uly 29, 2008	
		Melissa Brassell, MD Assistant Medical E		,	reet, Baltimore,	MD 21201			
St	ife	31. Date filed 331 h, 3 y yea 2008 gistr r's		A. A.					

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventuer traust be refifted at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, Last)			60		Date of Dea Month	ith , Da	av.	Year	3. Time of	Death
an al	Arthur William GSELL					avous		2 3	8000	9'5	DAM.
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location o	of Death		40	. County o			
	Washington County Hospital		Hage	rstown	1			Wash	ingto	n	
	5. Social Security Number 6. Sex 7. Age (In yrs. last		/ If Under 1 Year Months Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, <i>Year</i>))	9. Birthp	lace (State of	r Foreign
	204-03-4087	Yrs.				June 2	9 1	920		sylvan	ia
	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Fown or i	ocation	-					1	Od. Inside Cit	v Limite
5	Tod. State Tob. County Toc. City, 1	IOWII OI L	Cocation							1 🏹 Yes	
ect	Maryland Washington		Hagersto	wn			10 0				
늅	10e. Street and Number		10f. Zip Code					itizen of W	nat Coun	try?	
era	816 Corbett Street	140		1740		27. 34		ISA			
Š	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	. Was Decedent of I If Yes, specify Cub	an, Mexican	igin? (Spe n, Puerto I	Rican, etc.)			- Americ , White, 6	an Indian, etc.	
ğ	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give WW I 3 □ Widowed 4 □ Divorced Year or Dates: WW I	I	1 □Yes 2 📉 No	Specify:				Specify:		White	
Be Completed by Funeral Director			edent's Usual Occu	nation			16b. k	Kind of Bus			
Bet	(Specify only highest grade completed)	(Give	e kind of work done DO NOT use retire	during most	t of workir	ng				, and the	
E	Elementary/Secondary (0-12) College (1-4or 5+)	Teavy	y equipmen	nt one	erato	r	Cou	intv (Gove	nment	
o O	17. Father's Name (First, Middle, Last)		/			(First, Middle,					
임	John Edward Gsell			E1	lizab	eth Vic	1a	Carba	augh		
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ling Address (Street	1					<u>-</u>	Code)	
	Sallie Iona Gsell - Wife	816	Corbett	Street	. Ha	gerstov	m,	Md.	21740)	
	20a. Method of Disposition 20b. Plac		oosition (Name of ematory or other pla			ate		ocation - 0			
	1 Light Burlai 2 Li Cremation 3 Li Removal from State		en Cemete:	i .	3/5/0	18	Нао	reret	own.	Mary1	and
	21. Signature of Funeral Service Licensee		22. Name and Addre			nnich H				1101) 11	arra
	Fred L. Vestal	1	415 E. Wi	lson E						L740	
	23a. Part 1. Enter the disease, or complications that caused the death.									Approximate	
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nic	Adev	100	0//			-		Interval Bet Onset and I	veen Death
	disease or condition resulting in death) a. Due to (or as a consequence)	, -	1700	100	4	(M OM	حو	9			
	Lista Consequen	ice oi).									
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):									
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	Cu	ncer								
Ex	resulting in death) Last Due to (or as a consequent	nce of):									
cian/Medical Examiner	d										
led											
Jug V	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnanc 1		□ Estania prognan	~				23d. Date	e of delive	ery	
Sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea		Other (specify)	СУ				Mor	nth	Day \	rear .
Physic	9 ☐ Unknown										
y F	Part II. Other significant conditions contributing to death but not resulting	ng in the	underlying cause gi	ven in Part I		23e. Did to	obacco	use contri	ibute to th	ne cause of d	eath?
9	prostate caretrock				-	1 🗆 \	es 2	2 □ No	3 Prob	ably 4 □ l	Jnknown
plet	Acrie level failu	e				24a. Was		24b. V	Vere auto	psy findings	available
E							rmed? 2 ⊒•N	d	eath?	mpletion of c	ause oi
ě	25. Was case referred to medical			26. Place	e of Death	(Check only o		<u> </u>		2 🗆 140	
2	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ EF	R/Outpatie	ent 3 DOA Ott	ner: 4 □ Nu	ursing Hor	me 5 Resid	dence	6 □ Othe	er (Specif	y)	
Ë		Bb. Time Injury		ry at	2	28d. Describe h	now inju	ury occurre	ed		
atic	2 Accident investigation	,,]Yes 2□	No						
tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, s	treet, factory, office		2	28f. Location (S City or Tov	Street a	and Numbe	er or Rura	I Route Num	ber,
Cer							,,, 5,,,,	.07			
Medical Certification: To Be Completed by	29a. Certifier (Check only one) Medical Examiner: On the basis of examinatio and manner stated.	edge, dea n and/or i	ath occurred at the tinvestigation, in my	ime, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(date ar	(s) and ma	nner as s	tated. the cause(s)
Me	29b. Signature and title of certifier		29c. Licen	se number			29d. D	ate signed	I (Month.	Day, Year)	
	Januale Doseed			061	115	7	An	CUC	T		008
	30. Name and address of person who completed cause of death (Item 2	3a) /Tuno		0 \ (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		\ <u>+</u> =	7	0,3		-(~	0
	Francisco A Daniels,	120	> H		721	m V	1 K	2 6	217	42	
ite ar	31. Date filed (Month, Day, Year) AUG 0 5 2008 32. Relistrar's Signatur	e	Social								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0

DHMH 17 Rev 1/2001

Sta Registi

SHIDTI

Registrar

State

DHMH 17 Rev 1/2001

MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

M.D

eğistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

49901

NIGAM

3 1 2008

MAHDU

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 3:56 PM July Margaret Ann Helmka 25 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 7190 West Sundown Court Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country)
Sept. 25, 1928 New Jersey Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🔯 I 154-20-8666 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7190 W. Sundown Court 21702 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Local Government would be file.
7 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel White Helen Goslin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and Carol Helmka / Daughter 7190 W. Sundown Ct. Frederick, MD 21702 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) . Date 2 20c. Location - City or Town, State 20a. Method of Disposition Aug. 2 2008 Important: If it any Injury or o 1 N Burial 2 □ Cremation 3 N Removal from State 4 □ Donation 5 Other (Specify)

21. Signature 11 Ineral Service Censee Hamilton Cemetery |Neptune, New Jersey Resthaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, shock, or heart failure. Li Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Resp. for Cordio-Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed A12 heimer burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Parleinson Dise 150. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes ၾ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 29a. Certifier Æ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 120922 a to in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 Prafull Dave, M.D. 188 Thomas Johnson Drive, Ste. 200 Frederick, MD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) MI 3 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:59 PM Vikki Lucinda Hedrick 2008 Aug /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 22209 Jefferson Blvd. Smithsburg Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 X F 217-58-3864 08/09/1951 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at MD Washington Smithsburg 1 ☐ Yes 21 No Director filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 22209 Jefferson Blvd. US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕱 No Specify: þ ear or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t and 2 should be filed within lealth and Mental Hygiene. on 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 冒 Medical Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ellsworth Whittington Betty Jean Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22209 Jefferson Blvd., Smithsburg, MD 21783 Department of Health a Important: If item 27 is any injury or other tra once. Michael W. Hedrick / Husband of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Smithsburg Crematory 08/04/2008 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Fucial Sprvice Licens 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 X No P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 2X No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death.

I Director: After d in by the funers After 5 Pending investigation 1 🖾 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H40884 08/04/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-12 III, 251 E. Antietam Street, Hagerstown, MD 21740 Thomas J. Gilbert, 31. Date filed (Month, Day, Year) State AUG 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	State	n waryia		artment of <i>rtificate o</i>			entai i	Reg. No.	201	18 261
Physicia /Medic		1. Decedent's Name (First, Mi Bett				2. Date of Month	Day	20	3. Time of Death 10:55 P			
Examine	_	4a. Facility Name (If not institu	ution, give street and nu altimore Me		onter	4b. City, Town	n, or Location	of Death			ounty of D 1 tin	
Funeral Director		5. Social Security Number 219–36–4127	6. Sex 1 □ M 2 🛣 F		s. last birthday) 66 Yrs.	If Under 1 Ye Months Day	ar If Under	24 Hrs. Min.	8. Date of (Month, Jan.	Birth Day, Year) 8, 1942		Birthplace (State or Fore Country) Maryland
ס		Usual Residence of Decedent 10a. State 10b. Cou		10c. C	City, Town or Lo	cation						10d. Inside City Lim
he Mary 28a-f sh otlfied	Director	Maryland Wash	nington	Ha	agersto	10f. Zip Cod				10g Citize	n of Wha	1 ☐ Yes 2★
th with t 23a or 3	al Dir	14172 She1by	Circle				21740			U. S	5.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Iniportant: I flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2점 N 3 □ Widowed 4 □ Divor	Armed F Married 1 ☐ Yes If Yes, G	2 XNo ive		Was Decedent of Yes, specify C	No Specify		cify Yes or Rican, etc.)	s	Black, t	American Indian, White, etc. white
ed within 72 horigine.	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1 12	dent's Education ghest grade completed College 0) (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei ception:	ne during mo tired)	st of workin	ng	Ĩ	of Busin	ness/Industry
d be filed ental Hygi ced other c event, ti	Be	17. Father's Name (First, Mid							(First, Mio	dle, Maiden S Wint		
nd 2 should Ith and Men 27 is marke traumatic	P_	19a. Informant's Name/Relati	ionship (Type. Print)			ng Address (Str		oer or Rura	l Route Nu	mber, City or	Town, Sta	
mit. Pages 1 and partment of Health portant: If item 27 y Injury or other toe.		George W. Ha	ion 3 Removal fron	20b	. Place of Dispo cemetery, cre	2 She1by sition (Name of matory or other wn Crema	place)	Augus	st 3,	20c. Loca	ation - Cit	land 21740 ty or Town, State wn, Maryland
permit. P Departme Importan any Injury		4 Donation 5 Other 21. Signature of Funeral Service 1		-	2	2. Name and Ad	Idress of Faci	11.	innic	h Funer	cal I	
Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complications that List only one cause on a. Ac Due to	caused the de each line.	eath. Do not en	ter the mode of	dying, such a DISTIE.	s cardiac o	Syna	rome		Approximate Interval Betweer Onset and Deat
physician and sthe burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	o (or as a cons	equence of):							
the death certifica y the attending ph ched for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown	¹ 1□Live	utcome pf preebirth 2 ☐ F gnant at time conown	etal death 3	⊒Ectopic pregna □ Other (specif)				_ 23	3d. Date Monti	of delivery h Day Year
w requires that the d	by Ph	Part II. Other significant cor	omyelito		resulting in the t	inderlying cause	e given in Part	H.		oid tobacco us		ute to the cause of death
sician; The law requirection, page 2 should	Completed	05 12	o my corre						24a. \	Vas an autopsy performed	24b. We	ere autopsy findings avail or to completion of cause ath? Yes 2 \sum No
ysician; is certific director,	Be	25. Was case referred to me examiner? 1 Yes 2 No	Hannital:	Inpatient 2	2 ☐ ER/Outpatie	nt 201004	Other:	ce of Death		nly one) Residence 6	- Other	(Create)
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Death T■ Natural 5 □ Pe 2 □ Accident in 3 □ Suicide 6 □ Co	ending (Mo	e of Injury onth, Day Year	28b. Time Injury	of 28c.	Injury at Work? 1 ☐ Yes 2 []No	28d. Descr	ibe how injury	occurred	
Hospital or the hours aft Funeral Dittely filled in	Medical Cer	29a. Certifier 1 Cert (Check only one)	tifying Physician: To t lical Examiner: On the	he best of my basis of exam	knowledge, dea	th occurred at the	ne time, date	and place, eath occur	and due to	the cause(s)	and man	ner as stated. nd due to the cause(s)
To the To the Complet	Med	29b. Signature and title of ce		anner stated.	MD	29c. Lio	cense number	82	-	29d. Date	signed	(Month, Day, Year)
17		30. Name and address of pe	rson who completed ca	use of death (Item 23a) (Type	, Print)					,	12 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ruby Janette Hoffman July 27 2008 8:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Carroll County Manchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2▼F Hours 219-14-1715 84 Director Dec. 18, 1923 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Maryland Carroll County Director Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Terrace Court. 21074 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) secretary manufacturer 12 marked other ימומ Should be fi. nert of Health and Mental Hy nt; if item 27 is marked ייי y or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dan Milam Quinley, Sr. Pages 1 and 2 should finent of Health and Men Rose Ann Noe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Barnes - daughter 1005 Terrace Court Hampstead, Maryland 21074 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 1 2008 permit. Page Department o Important; If any Injury or Manchester Baptist Cem. Manchester, Maryland 21. Signature of Funeral Service License Eline Funeral Home 22. Name and Address of Facility M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4THEROSCIEROTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Examiner Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregpant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has been si ge 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate ha performed death? 1 ☐ Yes 2/ENO 1□ Yes 2 No funeral director 25. Was case referred to medical Be 26. Place reath Check onl one examiner' Hospital: 1 Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural Injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WJZ

arrien

JUL 3 0

IRSNEEM 4

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

EAKITAMI,

28 35

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

			Pleas	e Type or Print in	Black Ir	ndelible Ink	. Ensure	All Copie	s Are	Legible.	
			For	State of Maryla				Mental H	ygiene	2008	26196
			1 - State Registrar		$C\epsilon$	ertificate of	Death		Reg. No.		
	Physicia	an	Decedent's Name (First, Middle, STDTA)					2. Date of D Month	Day	Year	3. Time of Death
	/Medic		MIRIAM 4a. Facility Name (If not institution,		IARVEY	4h City Town	or Location of Deat	July	29	County of Death	<u> </u>
	Examin	ei	4- / /	munity Hosp	Ital	La	nham	,		ina Ge	
	Funeral			Sex 7. Age (in y	rs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		·	9. Birth	place (State or Foreign
	Director		578-46-1499 Usual Residence of Decedent	1□M 2XF 73	Yrs.	Monaro Bayo		DEC.			SH. D.C.
vland	MO NI		10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
Mar	a-f sh	ctor	MD. PRINCE	GEORGES		UNTVERS	ITY PARK				1 XYes 2 No
ith the	or 28	Director	10e. Street and Number			10f. Zip Code		-	10g. Citi	zen of What Cou	intry?
3-UU36 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at		4412 EAST WE				0782			U.S.	
ter de	item iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2X No	1 U.S. 13.	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	 Race - Amer Black, White, 	
5-UU35 72 hours aft	al', o	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2X□No	Specify:			Specify: WHI	TE
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filed A	Hygin Sther ent, II	ပ္ပ	17. Father's Name (First, Middle, La	st)		HOMEMA	18. Mother's Nar	me (First, Middl	e, Maiden	HOME Surname)	
d be	dentai	To Be			J	JNK.		/IOLA		FITZGER	C.TAS
lary 2 shou	and Menta is marked aumatic ev		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street			ber, City o		
and 2			BERNARD R. HA		4412		EST HWY,				
ges 1	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cre	osition (Name of ematory or other pla		Date	20c. Lo	cation - City or T	own, State
arumor mit. Pages	Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Light			CREMATO 22. Name and Addre		2008	RI	VERDALE,	MD.
De me	Depa Impo any Ir once		MAL Chi	5	00091	CHAMBERS 801 CLEV	FUNERAL F	HOME & C	REMA'	TORIUM, F	0.0737
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de						u, 1m. 2	Approximate Interval Between
√ Ph	nysician		Immediate Cause (Final disease or condition	y one cause on each line.	Free	ture		WI	per l		Onset and Death
	Medical kaminer		resulting in death)	a Due to (or as a cons	equence of):	10,0	19				10000
L		<u>.</u>	Sequentially list conditions, if any, had in the immediate	b. Fall	CONTRACTOR OF		10/1/	398			10 days
uted	insit	Examiner	Cause (Disease or injury	Due to (or as a cons	wquenge orp:	0.0	Je 1600	, ,			
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ficate be	hysici he bu	Physician/Medical		d		p_					
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eath	atten for us	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ For a Pregnant at time of	etal death 3	☐ Ectopic pregnand	СУ		4	23d. Date of deliv Month	very Day Year
te d	by the	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unknown	orueani 5	□ Other (specify) _					
J, T	gned t	by P	Part il. Other significant conditions	contributing to death but not r	resulting in the u	underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
equire	en siç		Pulmona	ry Embolisi	3			10	Yes 2[□ No 3 □ Pro	bably 4 Unknown
iaw r	as be	Completed	Atrial	Fibrillation	1			24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
The	icate r, page	ပ္ပ	Chronic	obstructiv	e Pulm	enary D	isease	per	ormed? 2 DNo	death? 1 □ Yes	_
Siciar	certif	Be	25. Was case referred to medical examiner?	Hospital:		opt 3 🗆 DOA Oth	26. Place of Dea				
2 4	er this	은	1⊟Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Injur	ry at	lome 5 ☐ Res 28d. Describe		Other (Special occurred)	AT
andin .	ath. r: Aft re fun	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	on 07/18/260	Injury	I Wor	k? Yes 2.5¥No	Lost L	ier ba	lance + f	
r Atte	irecto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Injury At	home, farm, st			28f. Location City or To	(Street and		al Route Number, ERSITY YARK
oital C	urs af erai Di		00-0-15-	home	2			4412	FAST	WEST HW	1. Md.
Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my kaminer: On the basis of exam and manner stated.	nowledge, dea ination and/or i	th occurred at the tinvestigation, in my o	me, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) , date and	and manner as place, and due t	stated. to the cause(s)
To the	within To the	ğ.	29b. Signature and title of certifier	and manner stateg.		29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
	10		> SET-	0		D	37934	1	71	129/20	cf
7			30. Name and address of person wh	, ,	tem 23a) (Type,	Print) renwey (+	- Deira Co	renh = 1+	10	20770	
	-01-		31. Date filed (Month, Day, Year)	22. Mgistrar's Sig			- Mine Of	Compet 1	ن		
	Stat Registra		JUL 3 1		H A	racks ?					

executed physician and s the burial-trans Box 68760, requires that the death certificate be use as attending p P.0. the ģ page 2 should be det Records, The

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 3 2008 **EULA** C. HARRIS /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1□ M 2 ☐ F Months SOUTH CAROLINA 84 239-28-1801 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exempter to ust be notified at 1X Yes 2 □ No Director PRINCE GEORGE'S LARGO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 706 NEW ORCHARD PLACE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th HOUSE KEEPER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE MCCOY GERTRUDE CARMICHAEL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 WHISTLING DUCK DR. UPPER MARLBORO, MD 20774 DENISE Y. DALEY/DAUGHTER Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State MD. NATIONAL CEMETERY 8/5/2008 LAUREL, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner PENTENSI that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1520 2 1 No Division of Vital 1 □Yes 2 □No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HNo 1 Hnpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAO, COMM. HOSPITAL OOR 5. DOCTUM 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** IRWIN 2008 JUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSP274L If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 6 Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Washington, D.C 72 7/15/1936 Director 579-46-8641 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wadical Evantible must be notified at 1 XYes 2 No Director Prince George's Hyattsville 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5904 Beecher Street 20785 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Gertrude Francis Farrell William Mann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 i 4721 Olympia Ave., Beltsville, MD 20705 Laurie A. Mountjoy, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ö 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 8/1/2008 Brentwood, MD 21. Signature of Emeral Service Ligens e 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 elins Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONZ Unknowil Physician /Medical resulting in death) Due to (or as a consequence of): Examiner VAKNOWA Sequentially list conditions, Due to for as a consequence off Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical signed by the attending I IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been signed 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 1 □Yes Hospital or Attending Physician; 24 hours after death.
Funeral Director: After this certifica filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Beath 1 Natural 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar JOHN KOTTARTHZL, 3001 SOUTH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hotherfil MD

31. Date filed (Month, Day, Year) AUG 0 1 2008

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

HANNOVER STREET, BALTIMORE

JULY, 28, 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2008 July 26, 9:55 PM John Ellsworth Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Kline Hospice House Mount Airy Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩M 2□F 71 Director 215-34-5119 March 10, 1937 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5711 Nottingham Place 21710 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after if Hygiene.
other than "natural", or ite 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator 12 Stone Quarry 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H; I tem 27 Is marked oth 17. Father's Name (First, Middle, Last) Be Howard Johnson Claudia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Stephens / Daughter | 5711 Nottingham Pl. Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 28, 20c. Location - City or Town, State **t** o Department of important: If It any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Resthaven Crematory 4 □ Donation 5 □ Other (Specify) 2008 Frederick, Maryland 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Hemorrhage 40 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the 28 attending I 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown cate hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Coronary Artery Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitei or Attending 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 22101 July 28, 2008 person who completed cause of death (Item 23a) (Type, Print) Lloyd Halvorson, M.D. 1475 Taney Avenue, Frederick, MD 21702

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 26200 08-05948 State of Maryland / Department of Health and Mental Hygiene Carlester Jackson 1- For State AMEND#160 HEALTH DEPT 8/8/08 CMC Certificate of Death Reg. No 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) hysician/ Month Day August 3, 2008 2012 hrs (Examiner Carlester Jackson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Maryland Director 52 Yrs 219-64-8912 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or items 23a or 28a-f show must be notified at once. Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 402 A Silverleaf Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 1 X Yes If Yes, Give Year 1 9 7 4 – 80 Yes 2X No specify: Specify: Black Divorced permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Truck Centran Trucking CO. during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 kina Co. 10th O Truck 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha E. Creek James M. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Silverleaf Ct. Glen Burnie, Md. Victoria V. Jackson(Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation Maryland Veteran 8-12-08 Crownsville, Md. Donation 5 Other Specify M Mame and the consense of Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval lysician Between Onset and failure. List only one cause on each line. /Medical a Cocaine intoxication Immediate Cause (Final disease Examiner

Yes 2 XNo

Death

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

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ı	or condition resulting in death)	Due to (or as a consequence of	i):				
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sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of preging the live birth Pregnant at time of de yer Unknown	2 Fetal dea		nancy	23d. Date of delivery Month E	day Year
ey Phy	Part II. Other significant conditions		esulting in the underly	ying cause given in Part I.		acco use contribute to	the cause of death? pably 4 Unknown
Completed					24a. Was an autops perform	y prior to o ned? death?	topsy findings available completion of cause of les 2 No
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o Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	sing Home 5 F	Residence 6 Othe	г:
-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Fnd 8/3/08	28b. Time of Injury Fnd 6:30	1 Voc 2 V No	28d. Describe h	ow injury occurred	
Certification	2 Accident Investigat 3 Suicide 6 X Could not determine	28e. Place of Injury - At h	nome, farm, street, fac	ctory, office building, etc.	28f. Location (Son Town, Stor Bur	treet and Number or Ru ate 402 A Sil rnie, MD	ral Route Number, City ver Leaf C
edical C	29a. Certifier	ician: To the best of my knowled her:On the basis of examination a and manner stated.	dge, death occurred a and/or investigation, i	at the time, date and place, a in my opinion, death occurred	nd due to the cause d at the time, date a	ind place, and due to tr	ne cause(s)
Ě	29b. Signature and title of certifier	_ una mumar autos.		29c. License number		29d. Date signed (Mo	nth, Day, Year)
_	Dan muline	-1 111		O.C.M.E.		August 4, 2008	
	30. Name and address of person wh	o completed cause of death (Iter	m 23a)				

111 Penn Street, Baltimore, MD 21201

State

8 2008

Donna M. Vincenti, MD

Assistant Medical Examiner

gistrar's Signature

			_ For	State of Ma		Departme	ent of H	lealth and l	•	giene		0.600	
			State Registrar			Certifica	ate of	Death		Reg. No	2008	2620	
r	Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	eath Da	y Year	3. Time of Death	
	/Medic		William Thaddeu	s KNODE					Augus	_	2008	3:15 a	M
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ì	Funeral			Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last bi	Monti	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year,) Coui		
4,0	Director		220-10-3538		91	Yrs.			Aug.	30 1	916 West	: Virginia	1
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					1	I 0d. inside City Limit	ts
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	the N	Director	Maryland Washi 10e. Street and Number	ngton		Hagers	town_ Zip Code			10a Ci	tizen of What Cour	ntn/?	
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	item item	ü	 Marital Status Never Married 2 Married 	Armed Forces?		if Yes, s	 Was Decedent of Hispanic Origin? (Specify Yes or N if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 			J-	Black, White,		
36	urs aff	by F	3 X Widowed 4 □ Divorced	1 Yes 2 N If Sive Year or Dates:		1 ☐ Yes	2 X No	Specify:			Specify:	White	
21215-0036	ttura sal E	ed	15. Decedent's	Education	WW II	. Decedent's U	Isual Occup	oation		16b. K	(ind of Business/In		_
15	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	(Specify only highest g	rade completed)	,	(Give kind of life. DO NO	work done T use retired	during most of word)	rking			,	
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Maryland	ld be ental ked c ev	To B	Daniel Preston	Knode				Vesta	Kretzei	-			
7	should be fi and Mental H s marked ot umatic ever	-	19a. Informant's Name/Relationship		198	o. Mailing Addr	ess (Street				or Town, State, Zip	Code)	_
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ē,	F Health tem 27		20a. Method of Disposition	-8		of Disposition (i			Date		ocation - City or To		
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в			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do	not enter the r	node of dyir	ng, such as cardia	or respiratory	arrest,		Approximate Interval Between	
4	Physician		immediate Cause (Final disease or condition	Dev	u.ento	1						Onset and Death	
	Medical		resulting in death)	Due to (or as	a consequence	of):	-1:	Δ.	1			13/	_
	xaminer	,	Sequentially list conditions.	b. Hypert	. Apperter Sine Cardiovasular					11 Scare 20			
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):			·				
	te be executed sysician and ne burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	C									
,092	e exe		resulting in death) Last	Due to (or as	a consequence	of):							
876	ate b hysic	lical	•	d									_
68	death certificate attending physi	Mec	IF FEMALE:										_
Box	ath ce tend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	pf preg <i>n</i> ancy 2 □Fetal deatl	n 3□Ectopi	c pregnanc	y			23d. Date of deliv		
	0 0	sici	1 ☐ Yes 2 ☐ No	4⊡Pregnant at 9⊡Unknown	time of death	5 Other	(specify) _				Month	Day Year	
P.0	requires that the de een signed by the a rould be detached to	Physician/Medi	9 ☐ Unknown										_
	9 P 9	by	Part ii. Other significant conditions	contributing to death bu	it not resulting i	n the underlyin	ig cause giv	en in Part I.				he cause of death?	
ord	w requir been si should								1	Yes 2	P∏ No 3 ☐ Pro	bably 4 □Unknov	٧n
Records,	- 0 -	plet							24a. Wa		24b. Were auto	opsy findings availab	ole
æ	The ate his	Completed								opsy ormed? 2 ∑ N	death?	ompletion of cause of 2 □ No	1
Vital		Be C	25. Was case referred to medical					26. Place of Dea			1 1 103	-3.10	_
r <	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☐ 400	Hospital: 1 ☐ inpatie	nt 2 ER/O	utpatient 3□	DOA Oth	or.			6 ☐Other (Speci	fy)	
1 Or	5 ≠ 5		27. Manner of Death	28a. Date of inju		Time of Injury	28c. Inju	-	28d. Describe				_
Ö	ath. rr: Af	Sertification:	1	on		M		Yes 2 □ No					
Division	tal or Attending F s after death. al Director: After ed in by the funer		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At home, fa	arm, street, fac	tory, office		28f. Location City or To		nd Number or Run	al Route Number,	_
	talor s afte al Dir	Sen		Summy, ou	1-1-0-1/				Only of 10	·····, Gidi	~ /		

Medical

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

2323

29d. Date signed (Month, Day, Year) 8-04-200-8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid M. Waseem

1126 Opal Court, Hagerstown, Maryland 21742

31. Date filed (Month, Day, Year) AUG 0 4 2008

29a. Certifier

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:45 p July 28, Koskela 2008 W. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 15107 Interlachen Drive, #626 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Dec. 6, 1940 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1**X** M 2 □ F Michigan 368-40-4024 Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the modical Event is an ount to modified at 1 ☐ Yes 2 XNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20906 USA 15107 Interlachen Drive, #626 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after **KX**es 2 □ No 1 Never Married 2 Married If Yes, Give Year or Dates: 1959–87 1 ☐ Yes 2 ☐ No Specify White Baltimore, Maryland 21215-0036 Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government. Computer Systems Analyst 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Belanger Unknown Koskela ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15107 Interlachen Drive, #626, Silver Spring, Maryland 20906 Eloise Koskela/Wife permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition August 1 2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Park 4 □ Donation 5 □ Other (Specify) Olney, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 □Yes 2 certificate 26. Place of Death (Check only onle) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my acting the state of the cause of To the Hospital within 24 hours a To the Funeral D 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certif 30 2008 D 400 664 48 41 N 0 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe CENTER DRIVE, BLAG 10, RM 12N226, BETHESDA, MD G. KLUETZ ID PAUL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 3 1 2008 JUL Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Ju‱ 30, **Physician** 2:31 P. M KONICK Lillian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda <u>Suburban</u> Hospital 9. Birthplace (State or Foreign New Haven, CT Age (In yrs. last birthday) 8. Date of Birth May 29, If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** Days Hours Min. 043-18-7351 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f show nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Experience to ust be notified at 1 √ Yes 2 □ No Rockville Montgomery Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with 20852 U.S.A. 1801 E. Jefferson St., #307 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 □Yes 2X No White Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed New Haven, CT. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Public (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Health Services Statistician 18. Mother's Name (First, Middle, Maiden Surname)
ROSE POLICOW 17. Father's Name (First, Middle, Last)
William Konick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 Kersey Rd., Silver Spring, MD 20902 Ruthie Konick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t**X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Mt. Lebanon Cemetery | July 31,2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Rome, Inc 21. Signature of Fundal Service Licens 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Clostridium Difficile Colitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Taus to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗖 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 30, 2008 impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 20814 Natasha Haag, MD 8600 Old Georgetown Rd., Bethesda, MD 32. egistrar's Signature 31. Date filed (Month, Day, Year) 3 1 2008 Registrar

			_ FOr	Maryland / Dep			ientai Hyg		0.0001	
			State Registrar	Ce	rtificate of L	Death		eg. No. 2 () () {		
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	h Day Year	3. Time of Death	
	/Medic	_	George Ha	arold Lewis			August	6 2008		
,	Examin	er	4a. Facility Name (If not institution, give street and numb	,	4b. City, Town, or			4c. County of Dea	ath	
_	· · · · · · · · · · · · · · · · · · ·		Booth II Assisted Living		Rising	Sun If Under 24 Hrs.	8. Date of Birth	Ceci1	H-1 (0) - 5 - :	
	Funeral		1 V IM 2□ E	Age (In yrs. last birthday, Yrs.	Months Days	Hours Min.	(Month Day	Year) C	rthplace (State or Foreign ountry)	
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	land tt		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
	Mary f sh	ŏ	Maryland Cecil	Elkton	_				1 X Yes 2 □ No	
	the notif	Directo	10e. Street and Number	DZICCOI.	10f. Zip Code		1	0g. Citizen of What C	ountry?	
	3a ol		611 Skipjack Court		21921			United S	tates	
	ms 2	Funeral	11 Marital Status 12. Was Deced		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,	
)	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than Medical Examiner must be notified at	F	Armed Forc 1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 If Yes, Give	□ No T J T J	1 ☐ Yes 2 ☑ No	Specify:	rican, etc.)	Black, Wh		
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7	ithin ne. han a	Elementary/Secondary (0-12) College (1-4or 5+) 12 Receiving Clerk							ile	
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2	d 2 sk		Johanna K. Lewis/Wife		Skipjack (· ·	zip code)	
נֿט	1 and Health em 27 ther tr	11 3	20a. Method of Disposition		osition (Name of ematory or other place			20c. Location - City o	r Town. State	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from St	1110000	st 11,	,				
	artme ortani injuny		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensees	2008 ss of Facility	1	Leeds,	MD			
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	Physician	8 4	shock, or heart failure. List only one cause or enumediate Cause (Final	1		Do	1/	_	Onset and Death	
1	/Medical		disease or condition resulting in death) a.	r as a consequence of):	evis	vem-	ent "	a case		
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-	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
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5	n: Th icate r, pag						1□ Yes	2 No 1 □ Ye		
=	siciar certif	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) \(\text{Yes} \) \(\text{Vo} \) \(\text{Hospital:} \)		ont 30 DOA Oth	er.	th (Check only or		Assisted	
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5	al or s after il Dir ed in b	Certification:	4 Homicide determined building	g, etc. (Specify)			City or Tow	in, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 12 Certifying Physician: To the ba							
	the H in 24 the Fi	Medical	one) and manne	er stated.			ned at the time,		ue to the cause(s)	
	To To	2	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)	
ł			(2/0	~ · · · · · · · · · · · · · · · · · · ·	4D DOE	5644;	9	817/0	8	
			30. Name and address of person who completed cause	of death (Item 23a) (Typ	Print)	5 1	200	FIVI	UN Yan	
	- 0		31. Date filed (Month, Day, Year) 32. Re	DIL W - T	19h DT	- Juil	£ 500	- CILIAN	- rually	
	Sta	ite	ALIC 1 A 2008	A	-					

Donald Farrar Lu		1- For State	St	ate of Maryl	and / [Department Certificate			d Menta	al Hyg		Reg. No.	20	18	2621
Physicia		Registrar 1. Decedent's Nam	e (First, Midd	le,Last)							Date of De	ath	Vaar		ne of Death
Medical Examin		Donald H	arrar	Lundberg	, Sr.					J	Month July 28, 2		Year		248 hrs
Q_{F}		4a. Facility Name (i 19 Ridge R	f not institution	on, give street and n	number)		/	, Town, or ng Sun	Location of	Death			: County of Dea Cecil	ath	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (I	e (In yrs. last birthday) If Under 1 Year If Under 24th		_	B. Date of E	Birth (MM/	(DD/YYYY) 9. E		(State or		
Director		221-60-21	.05	1 X M 2 F	4	46 Yrs. Months Days Hours Min.			Min.	12/2	9/19	61	Country)	PA	
any		Usual Residence o	f Decedent 10b. County		10	c. City, Town or Lo	cation			-				10d. l	Inside City Limits
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arylan 8a-f st	Director	10e. Street and Nu				KIDING D		Zip Code				10g. Cit	izen of What Co	ountry?	
the Ma	Dire	19 Ridge	Road				21	911				Unit	ted Stat	tes	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumante event, the Medical Examiner must be notified at once.	eral	11. Marital Status		12. Was De	ecedent Ev		Was Dece	dent of His	spanic Origin, Mexican,				14. Race - Am White, etc.	erican Ind	dian, Black,
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5-0036 iled within 7/ Hygiene. I other than		17. Father's Name	(First, Middle	e, Last)					18. Mother's	Name (F	irst, Middle	e, Maider	Surname)		
121 d be fi lental I arked		David Eri				Tab Ma	lina Addes	ODD /Chap	Barba	ra E	xley	lumbor (City or Town, St	ate Zin (^ode)
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and 2 lealth tem 2		20a. Method of Dis	position			20b. Place of Dis	position (N	lame of ce			Date	20c.	Location - City	or Town	, State
Baltimore, permit Pages I an Department of Hea Important: If iter				n 3 Removal	from State	1		•		0.//./0	2000				
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Physician		28a. Part I. Enter t	he discase, o	r complications that e on each line.	caused th	e death. Do not ent	er the mod	de of dying,	, such as ca	rdiac or re	espiratory	arrest, sh	ock, or heart		proximate Interval etween Onset and
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Sox 68760 death certificate be attending physical for use as the bu	ian	23b. Was deceden past 12 month		,	e birth egnant at tir	me of death 5	Fetal dea		Ectopic	pregnand	СУ	- 3	Month	Day	Year
Box 68760 e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2	No 9 U	nknown 9 Uni	known	3_	Other (S	pecity)							
cords, P.O. B law requires that the de has been signed by the 2 should be detached 1		Part II. Other sign	nificant cond	itions contributing	g to death t	but not resulting in t	he underly	ing cause	given in Pa	rt I.			o use contribute		
S, P. irres th	d by	Cirrhosis	of liver, mo	orbid obesity											4 Unknown
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the functal director, page 2 should be detach	Bec	25. Was case refe examiner?	erred to medic						e of Death						
F Vid Physic r this	T ₀	1 ✔ Yes	2 No	Hospital:	Inpatien			DOA Inii	Other ury at Work		Home 5		dence 6 🗸 O	ther: Sce	ne
n of ding Ph		27. Manner of Dea		nding 28a. Da (Mo	ate of Injury onth, Day,Yea	ar)	OHIJUTY		Yes 2		.bu. Descri	DE HOW H	njary occurred		
Sio Atten r deatl ector: by the	cati	2 Accident	Inv	estigation 28e P	lace of Inju	ıry - At home, farm,	street, fact				28f. Locatio	n (Street	and Number o	r Rural R	toute Number, City
Divisior spital or Attend hours after death, uneral Director:	Certification:	3 Suicide 4 Homicide		uld not be ermined (Speci		,		,,	3 ,			n, State)			
Hospi 4 hou Funer ely fil		29a. Certifier	Certifying	Physician: To the t	best of my	knowledge, death o	ccurred at	the time, o	date and pla	ice, and d	lue to the c	ause(s)	and manner as	stated.	
To the He within 24 To the Fa	Medical	one) 2 🗸	Medical Ex	aminer:On the bas and manne	is of examer stated.	ination and/or inves	tigation, in	n my opinio	on, death oc	curred at	the time, d				
F % F %	Me	29b. Signature an	d title of certif						se number				d. Date signed		Jay, Year)
		la	097	011	w			0.0	:.M.E.			Ju	ıly 29, 2008 		
				on who completed c			11 Don	n Stract	, Baltimo	re MD	21201				
		Tasha Gre		V		S Signature	n ren	n Sireet	, Daillill	TE, IVID	Z 1ZU I				
S Regis	tate trai		IG 1		latura.	Le As	ale								
DHMH 17 Rev 1/2	2001	-71		1		ORIGI	NAL								

			1 - For State Registrar		Maryland /	Depa		Health :	and Men	tal Hyg		008	262	206
			1. Decedent's Name (First, Middle,	Last)						Date of Deat	h		3. Time o	f Death
	Physici /Medic		Sam L	. Lant:	ion					\mathbf{uly}	23,	2008	4:35	5 P ^M
	Examin		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Town,	or Location	of Death	_		unty of Death		
			Holy Cross H	ospital			Sil	ver S	Spring	ing		Montgomery		
	Funeral		5. Social Security Number		7. Age (In yrs. last		If Under 1 Year Months Days	If Under	24 Hrs. 8 F	Date of Birth Month, Day,	9 Birthplace (State or Fr			or Foreign
	Director		Usual Residence of Decedent	¥ M 2□F	84	Yrs.				2-10-				
	Marylar I-f show	tor	MD. 10b. County MD. Mont	gomery	10c. City, To		rer Spr	ing					10d. Inside C 1 🙀 Yes	City Limits 2 ☐ No
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jical Examiraet must be nutified at	Funeral Director	10e. Street and Number 1000 Brunsw	ick Ave	nue. #21	18	10f. Zip Code	910		10	-	of What Cou	ntry?	
	Jeath The 20	era	11. Marital Status	12. Was Dece	dent Ever in U.S.				rigin? (Specify	Yes or No-		Race - Ameri	can Indian,	
36	rs after or itan		1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For 1 Tes If Yes, Give Year or Da	2 X No	1	lf Yes, specify Cul 1 ☐ Yes 2 ½ No	edent of Hispanic Origin? (Specify Yes or No- pecify Cuban, Mexican, Puerto Rican, etc.) 2 No Specify:			Sp	Black, White, etc. Specify: Black		
21215-0036	n 72 hou "natura	Completed by	15. Decedent's (Specify only highest	Education		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of working		16b. Kind	b. Kind of Business/Industry		
12	within iene. than "	mc	Elementary/Secondary (0-12) 12th	College (1-	4or 5+)					,	\u+om	obile (nos lecr	chin
ind 2	be filed Ital Hygie Id othar avant, It	Be	17. Father's Name (First, Middle, L.			ĸe	pairman		er's Name <i>(Fir</i>			mame)	Not	t
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Maileal Examiner must be nutified at	2	Lester Lan 19a. Informant's Name/Relationshi		1:	9b. Mailir	ng Address (Stree	at and Numb	er or Rural Ro	ute Number,	City or T		vaila Code)	ıble
	1 and 2 Health a tam 27 is		Gina Smith/	Daughtei	<u> </u>	911	Artil	lary	Lane,	Oden	ton	Md.		
J.e.	es 1 a of He fitam roth		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other pla		Date			tion - City or To	own, State	
E	Pages nent of ant: If its ury or o		1 Burial 2 Cremation : 1 Other (Specific Specific Sp		tate	-	Church	.	7/29	/08	Gast	on, N	. C.	
Baltimore,	permit. Page: Department or Important: If i any injury or once.		21. Signature of Funeral Service Li	censee (rised	22	2. Name and Addr The Hou	ess of Facili	f Wil	liams	Fur			
	400		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that canly one cause on ea	used the death. D	o not ent	814- UI er the mode of dy	ing, such as	Stree	et, N	est,		Approximat Interval Bet Onset and	tween
	Physician	7	Immediate Cause (Final disease or condition resulting in death)	_ a Pneı	ımonia								Gilloct and	Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consequenc	ce of):								
		-	Sequentially list conditions, if any, leading to immediate	b. Urir	nary Tra	act	Infecti	lon						
	bed lisit	Examiner	cause. Enter Underlying Cause (Disease or injury									- 1		
_	te be executed ysician and ne burial-transit	xan	that initiated events resulting in death) Last	c. <u>Clos</u>	stridium oras a consequenc	n Di	fficile	e Col	itis					
760,	be exician	icai E				, 0 0.,								
687	# × #		·	d. Seps	SIS									
.O. Box (at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnancy onth 2 Fetal dea ant at time of death wn		Ectopic pregnant Other (specify)	ру			230	d. Date of delive Month		Year
<u>~</u>	that the		Part II. Other significent condition	e contributing to de	ath but not regulting	n in the u	ndorhina oauso a	von in Part I		23a Did toh	32000 1150	contribute to t	he cause of a	death?
8	uires t signe Id be c	by	Disseminated									vo 3 ☐ Prol		
Ö	w requ	etec	DISSCHIMACEG	Inclave	iscurar	CUa	guracio)11	- 1					
Records,	a SS	Completed								24a. Was ai autops	V	24b. Were auto prior to co	ppsy findings impletion of c	
<u> </u>		Co								perform	Mo No	death?	2 🗆 No	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hannitalı			0.		e of Death (Ch		-/			
—	hys nis	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending		npatient 2 ER/0 f Injury 28t n, Day Year)	Outpatier Time of Injury	28c. Inju		ursing Home 28d.	5 🗌 Reside Describe ho			(y)	_
0	andil eath. or: A he fu	ati	2 Accident investiga	ition			M 1	Yes 2	No					
Division	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory, office			ocation (St. City or Town		lumber or Run	al Route Num	nber,
	To the Hospital or Attanding Primithin 24 hours after death. To the Funaral Director: After the completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the xaminer: On the ba	best of my knowled sis of examination er stated	lge, deati and/or in	n occurred at the t vestigation, in my	ime, date ar opinion, dea	nd place, and c ath occurred at	due to the ca the time, da	ause(s) an	d manner as s ace, and due t	stated. o the cause(s	s)
	o the	Me	29b. Signature and title of certifier		•		29c. Licen	se number		25	9d. Date s	igned (Month,	Day, Year)	
			Saima	Khow	valor		D58	965		1		30th	200	18
7	3					a) (T				10	419		200	
		114	30. Name and address of person w				*	בת מ	C C	14.3	20	010		
	Sta	te	Saima Khawa: 31. Date filed (Month, Day, Year)	32 . 04	gistrar's Signature	FUL	SE GIE	и ка.	. 5.5.	, Md.		910		
	Registr			2008	gistrar's Signature	Go	Believe							

			For State		State of	Maryland		artment of F ctificate of a	lealth and N <i>Death</i>	ental Hyرا ا	giene Zen No 2	008	26207	
			Registrar 1. Decedent's Name	(First, Middle, Las	st)			timodito or i		2. Date of Dea	ith		3. Time of Death	
	Physicia /Medic		Corm	ac B.	. I	Long				July	28	2008	5:43 A M	
	Examin	er	4a. Facility Name (If	_	e street and numb	per)			r Location of Death ckville			nty of Death n tgome		
_	Funeral		5. Social Security No	umber 6. S	ex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	<u> </u>	9. Birth	nplace (State or Foreign intry)	
-5	Director	}	142-12-46 Usual Residence of	192	X M 2□ F	84	Yrs.	Working Baye		Feb. 2	1924	New	Jersey	
	yland Now		10a. State	10b. County	-	10c. City	, Town or Lo	cation					10d. Inside City Limits	
	e Mar 8a-f sl	Director	MD	Montgome	ery	Roc	kville				40 0111	-614/h-4 Cou	1 ☐ Yes 2 📉 No	
	with the		10e. Street and Nun 4 Rice C					10f. Zip Code 2085	50		10g. Citizen IInite	ed Sta	_	
	death	Funeral	11. Marital Status	ourt	12. Was Decede		S. 13.		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		Race - Amer	ican Indian,	
036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, it is Modical Examiner must be realified at	þ	1 ☐ Never Marri 3 🌠 Widowed	ed 2 Married 4 Divorced	1 ∐Yes 2 If Yes, Give Year or Date	∑ No		1 ☐ Yes 2 🏋 No	Specify:	7 110411, 0.0.7		ecify: Wh:		
21215-0036	"natur	Completed	(Spec	15. Decedent's Ed	ducation ide completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kind o	of Business/Industry		
212	l withir giene. r than	omo	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)		arch Asso			D.C. I	C. Public Schools		
Maryland 2	d be filed ental Hyg ced othe	Be	17. Father's Name (18. Mother's Nam Sarah		Maiden Surr	name)		
ary	should and Me s mark umatio	우	19a. Informant's Na	9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number, City or Town, Street and Number, City or Town, Street and Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number, City or Town, Street								wn, State, Z	ip Code)	
Ž	and 2 lealth a m 27 is		Adam J. Long (son) 4 Rice Court Rockville, MD 20850 20b. Place of Disposition (Name of Date 20c. Location - Cit								on City or T	Four State		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Experiment must be retified at once.		3 ()								ndria,			
Balt	permit. Depart Import any inj once.		21. Signature of Fu	ineral Service Cicer	isee				ess of Facility De eer Park				MD 20877	
			23a. Part 1. Enter the shock, or hea	he disease, or com irt failure. List only	plications that cau	used the death th line.	n. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximat Interval Between Onset and Death	
Vin.	Physician /Medical		Immediate Cause (disease or conditio resulting in death)		a. <u>-</u>	ratory r as a consequ		re					Onset and Death 1 Month	
	Examiner				4			ve Pulmor	nary Disea	ase				
	ed sit	iner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or											
	execut n and al-tran	Examiner	that initiated events resulting in death) I		c. Due to (or	r as a consequ	uence of):							
68760,	icate be executed physician and the burial-transit	d												
39 x	sertifica ding ph se as th	/Med	IF FEMALE:	- 4	23c. If yes, outco	ome of pregna	ancv		9589		224	Date of dell	lvorv	
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 1 Yes 2 5 9 Unknown	months?	1 Live bir	rth 2 ☐ Fetal ant at time of d	Ideath 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		230.	Date of deli Month	Day Year	
o.	res that the signed by be detaction	by Ph	Part II. Other signif		contributing to dea	th but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	
ord	w requires s been sig should b		General	ized Art	erioscle	rosis				1 🗆 '	Yes 2 □ N	lo 3∏ Pr	obably 4 XUnknown	
<u> </u>	The ate h	Completed								24a. Was autoj perfo 1 □ Yes	rmed?	prior to death?	topsy findings available completion of cause of 2 \square No	
/ita	ysician; The iis certificate h director, page	Be	25. Was case refer examiner?		Hospital:			Ott	26. Place of Dea	th (Check only o	ne)			
of	ding Physics After this of funeral dire	- To	1 ☐ Yes 2 🔀 27. Manner of Deat		28a. Date of		28b. Time o	III 3 LI DOA		ome 5X Resi 28d. Describe			cify)	
ion	arth. rr: Afte	atior	1 K } Natural 2 □ Accident	5 Pending investigatio	n .	, Day, Year)	Injury		rk?]Yes 2.∏No					
Divis	I or Attending Physician; after death. Director: After this certifics I in by the funeral director, p	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place o building	f Injury - At ho g, etc. <i>(Sp</i> ec <i>if</i>	ome, farm, str	reet, factory, office		28f. Location (City or To	Street and N wn, State)	umber or Ru	ural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)			sis of examina			time, date and place opinion, death occu					
	To the within 2 To the complet	Me	29b Signature and	title of certifier		~/	7).,		se number				h, Day, Year)	
	5		Deo.	recoll.	Doug	scac	RM	2	12121		July	28, 2	<u> </u>	
			30. Name and addr Dr. Geor	rest of person who	ngstack	M.D.	3929 F	Print) errara Di	r. Wheat	on, MD	20906			
	Sta Regist		31. Date filed (Mon	oth, Day, Year)	2008 32. 1	gistrar's Signa	ature	perte						

	,	For State of Maryland 1 - State Registrar		rtmen tificate			d Mental H		2008	2620	
Physici		Decedent's Name (First, Middle, Last)	Marti	n			2. Date of D Month August	eath Day		3. Time of Death 9:20 A. M	
/Medic		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location of D			County of Death		
		14429 Daley Rd.			-	town	, , , , , , , , , , , , , , , , , , , ,	- 1	ashingto		
Funeral Director	ý	5. Social Security Number 6. Sex 1 ☐ M 2 □ 7. Age (In yrs. last	st birthday) Yrs.	If Under Months 8	Days 21	If Under 24 I Hours N	Hrs. 8. Date of B (Month, I Nov. 20	irth Day, Year) 2007	9. Birth Count Pen	place (State or Foreign ntry) ina •	
and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	ation					1	10d. Inside City Limits	
Mary a-f sho fied a	tor	MD. Washington H	lagers	town					1 ☐ Yes 2 No		
ith the	Direc	10e. Street and Number		10f. Zip					en of What Cou	ntry?	
leath with the Marylanns 23a or 28a-f show must be notified at	Funeral Director	14429 Daley Rd. 11 Marital Status 12. Was Decedent Ever in U.S.	10.14	Vas Doood	2174		(Capaily Vac or B		S.A. 4. Race - Americ	can Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Marital Status 1 Marital Status 1 Marital Status 1 Marital Status 1 Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1	If	Yes, spec	ify Cuba	Specify:	? (Specify Yes or Nuerto Rican, etc.)		Black, White, Specify: Whi	, etc.	
72 hou natura Ilcal E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced			ition during most of	working	16b. Kin	nd of Business/In	idustry	
within and than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT us	e retired) Non	_			None		
filed Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)					Name (First, Midd	e, Maiden S			
Wenta be wild be arked arked attlc ev	To B	Michael R. Martin	Me1a	nie S. M	artin						
12 sho h and h r Is ma		19a. Informant's Name/Relationship (Type. Print) Michael R. Martin/Father					r Rural Route Num			code)	
Healtl Healtl tem 27		20a Method of Disposition 20b Pla	ce of Disnos	sition (Nam	ne of		erstown,	,	21740 cation - City or To	own, State	
Pages lent of nt: If if		1 Burial 2 □ Cremation 3 □ Removal from State Reif:		mite			12/08	Cea	arfoss,	Md.	
permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee H. Marte Jermein Gr.	Z	. Namé an imme r	man	s of Facility And So isle S	n Funera t. Green	l Home	e Inc.	7225	
		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of ach line.								Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition a. les prutto.	m F	uilure						Onset and Death	
Cate be executed by Medical Examiner but so it the purial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque cause (or as a conseque cause). Due to (or as a conseque cause).	nce of):	At	اود	sTyri	F (Wer	daig)to/Yman)	Conzenite	
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal design 4 □ Pregnant at time of deal 9 □ Unknown	leath 3□	Ectopic pro Other (sp				2	3d. Date of deliv	rery Day Year	
uires that signed b d be deta	by	Part II. Other significant conditions contributing to death but not result	ing in the un	derlying ca	use give	n in Part I.			_	the cause of death?	
w requ	letec			_		 -		•		opsy findings available	
The lav	Completed							opsy formed? 2 No	prior to co death? 1 ☐ Yes	ompletion of cause of 2□ No	
sician: The lacetificate ha	Be C	25. Was case referred to medical examiner?					Death (Check only				
Physic this cral dire	- To		R/Outpatient			4 🗀 Nursin	ng Home 5 Re			fy)	
th. :: After	tion	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	М	Bc. Injury Work 1 □ \	? ′es 2∐No	20d. Describe	e now injury	y occurred		
al or Atters a stransfer dea	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	e, farm, stre	et, factory	, office			(Street and own, State)		ral Route Number,	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.									
To the within To the COMMI	Σ	29b. Signature and title of certifier			License				e signed (Month,		
		TU) Iden			v0-	0434	06E	141	ugust	8005,11	
		30. Name and address of person who completed cause of death (Item 2	(Type, F よ207.	1964	Bu	lames Tr	06 E wil Fast	Ch.	of fring	Pa 12771	
Sta	te	31. Date filed (Month, Day, Year) 32. Pagistrar's Signatu	re		-000	A STORY	VII ICASI	1010	20.00	1-1100	
Registr	ar	ALIG 1 4 2008 A	6	- 40							

ORIGINAL

26209

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment rests be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Certificate of Death Reg. No. 201								2000	20	200	
		1. Decedent's Name (First, Middl	le, Last)				2. Date of D				Death	
hysici		James Daniel Ma	arks. Ir				July 26	Day 20		7:55	P M	
/Medic		4a. Facility Name (If not institution		mher)	4h City Town, o	or Location of De			County of Death	1,		
Examin	ier		_									
		Homewood at Cru 5. Social Security Number	miand far	TMS 7. Age (In yrs. last birthday)	Frederic If Under 1 Year		rs. 8. Date of Bi		ederick	place (State)	or Foreign	
ıneral			1. M 2□ F		Months Days		av. Year)	926Mary	place (State ontry)	or congre		
rector		216-22-7946 Usual Residence of Decedent		81 Yrs.			Sept.	20, 1	920Mary.	Lanu		
*		10a. State 10b. County		10c. City, Town or Lo	cation				1	10d. Inside C	ity Limits	
Sho	5									1 X Yes	2 🗆 No	
8a-f	ect.	Maryland Freder	rick	Frederick	1401 7: O- 15			10a Citi-	zen of What Cou	ntru?		
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Expedient mast be notified at once.	급	10e. Street and Number			10f. Zip Code			Tog. Citiz	zen or writat cou	itti y :		
239	<u>a</u>	1001 Carroll Pa			21701			USA				
MET.	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U.S. 13. erces?	Was Decedent of f Yes, specify Cut	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0- 1	 Race - Ameri Black, White, 			
P. E.		1 ☐ Never Married 2 🕅 Mar	If Vas Gi	2 No ve 1 n 1 1 1 1	1 □Yes 2 X]No	Specify:			Specify:			
E E	d by	□ 3 Widowed 4 Divorced Year or Dates: 1944-46										
hatt	Completed	15. Deceden (Specify only highe	nt's Education ast grade completed)	i (Give	dent's Usual Occu kind of work done	during most of w	vorking	T	nd of Business/In			
lan,	덛	Elementary/Secondary (0-12)	College (l-4or 5+)	DO NOT use retire	ed)		1	apeake a		tomac	
t, #	S	12		Test I	eskman				phone Co	ompany		
d oth	Be	17. Father's Name (First, Middle,	Last)			18. Mother's N	lame (First, Middle	e, Maiden :	Surname)			
arke atic e	To	James Daniel Ma	arks		****	Gladys	Clerene	Mily.	ard		.,	
S ms		19a. Informant's Name/Relations	ship (Type. Print)	19b. Maili	ng Address (Stree	et and Number or	Rural Route Num	ber, City oi	r Town, State, Zi	p Code)		
27 i er tra		Mary Alice Davi	is Marks,	wife 1001	Carroll	Parkway	, Freder:	ick,	Maryland	1 2170	01	
oth o		20a. Method of Disposition		20b. Place of Dispo			Date		cation - City or T			
#: با م		1 Durial 2 □ Cremation 4 □ Donation 5 □ Other (S		State Mount 01:			1 30 2008	Fred	erick N	Marvla	nd	
injur												
any		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701										
		23a, Part 1. Hitel the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
		shock, or heart failure. List only one cause on each line. Immediate Causs (Final										
sician		Immediate Carls (Final disease or condition a. Prostate Cancer Years										
edical		resulting in death)	- u.	(or as a consequence of):		Λ	eV°	W.	W			
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	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Examiner	Cause Diversity Cause Olivers or injury that initiated events c.										
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Ise		IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy				23d. Date of delivery		very		
for I	cial	in the past 12 months?			□ Ectopic pregnar □ Other (specify)	псу		Month Day			Year	
hed	Physician	1 □ Yes 2 □ No 9 □ Unknown	9 □ Unki									
detac	유	Part II. Other significant conditi	ions contributing to d	eath but not resulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute to	the cause of	death?	
agin a	þ	Subduralhemato					ion 15	lyes 2	X No 3 ☐ Pro	bably 4□	Unknown	
ono	ted	Dabdatathemae	oma ana m	teraceresiar_i	recu, ny	per cono.						
2 St	윤						_ 24a. Wa _ aut	opsy	24b. Were aut	opsy findings ompletion of		
oage	Completed						per	formed? 2 X No	death?	2 🗆 No		
tor,	Be C	25. Was case referred to medica	al			26. Place of I	Death (Check only					
direc		examiner? 1∭Yes 2 ☐ No	Hospital:	Inpatient 2 ☐ ER/Outpatie	nt 3 DOA O	ther: 4 🕅 Nursin	g Home 5 ☐ Re	sidence 6	3 □Other (Spec	eify)		
eral	Certification: To	27. Manner of Death	28a. Date	of Injury 28b. Time of	f 28c, Inj		28d. Describe	how injur	y occurred			
fun	틸	1 ☐ Natural 5 ☐ Pendir 2 🛣 Accident investi	ng igation Jun .	#3,2008 9:00j) M 1	ork? ∐Yes 2.MZNo	Fell w	hile	moving :	in wal	ker	
ctor y the	fica	3 ☐ Suicide 6 ☐ Could		1			28f. Location	(Ştreet an	d Number o <u>r</u> Rui	ral Route Nui	mber,	
in b	ert:	4 Homicide	nined build	e of Injury - At home, farm, st ing, etc. <i>(Specify)</i> Nursing Home	. ,		174 <i>007</i> 0rV	7471 Pt ets	v Road			
eral filled		29a. Certifier 1X Certifyi		e best of my knowledge, dea					Marylar)1	
Fun	Medical		I Examiner: On the I	pasis of examination and/or in iner stated.							(s)	
To the Funeral Director; completely filled in by the f	Mec	29b. Signature and title of certific		iller stated.	29c Licer	nse number		20d Dat	te signed (Month	Day Year)		
		23b. Signature and the or certific			250. Elder	13¢ Hamber		250, Da	to signed (month)	, 2 ay, 1 au,		
511		/ (/(,	D1642	.8		July	30, 200	08		
		30. Name and address of person	-									
		Casper Casper	E. Cline,	III, MD, 300	West Nir	nth Stre	et, Fred	erick	, Maryla	and 2	1701	
Sta	ate	31. Date filed (Month, Day, Year) 32. Register's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Register's Signature 45. Aparlia										
Registi			54 / /	Bild a If	The state of the s							

1511

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Janet Geraldine Mills 3:17 PM July 2008 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown, Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2√2 F 77 233-44-7377 Director 12-20-1930 Pierre, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at MD Washington Big Pool 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9548 Little Galilee Road 21711 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2√□No Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma A. Sheppard Harry Oliver Vanorsdale ပ 19a. Informant's Name/Relationship (Type. Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once. Charles E. Mills Jr 12402 Nesbitt Ave.Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkhead Cemetery 8-4-2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Big Pool, MD 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FAILURG /Medical Due to (or as a consequence of): Examiner PNEWMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed CONGETTIVE sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, EURA Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, s been signe should be d Completed by Pulmonary THE FRIEND I Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy Hospital or Attending Physician: The performed' certificate 1∐Yes 2 10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 2 To the and manner stated. To the MO 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month,

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ALITAKO-U

Day, Year)

AUG 0 4 2008

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egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) TULL **Physician** ANIL Κ. MAHAPATRA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days INDIA 230-15-8968 JAN. 28, 1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exportment be notified at once. 1∩a State 10h. County 1 ▼Yes 2 No Director PRINCE GEORGES BOWIE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3222 SCARLET OAK TERR. 20715 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: δ 3 Widowed 4 Divorced ASIAN INDIAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICES 4 SALES CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARAN MAHAPATRA INDUMATI NAYAK ပ BAISHNAB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SCARLET OAK TERR., BOWIE, MD. 20715 BABITA NAYAK/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7-31-2008 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A ranbeura - M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complication. If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardine Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 (No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29d. Date signed (Month, Day, Year) 08

Suite (of breenfelt, MD 20770 7500 Hanover Parkway 31. Date filed (Month, Day, Year)

State Registrar

31 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#11,16a,per1NF.,G882,8/28/08,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 26, 2008 Physician 2:30 P. M Lawrence Coldren Myers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth Month, Day, Year) June 15, 1921 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□ F Months Days Hours Michigan 373-18-6458 June" **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evertires must be rediffed at once. 10a. State 1X Yes 2 □ No Maryland Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 United States 203 East Franklin Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1943–1946 Year or Dates! Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Clerical Security Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Mills Coldren Archie Wright Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adam Myers/Son 8045 Tuckerman Lane, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo. Wash. University July 29
Medical Center 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4⊠Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. MA 9013 Annapolis Road Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Severe Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transil Atrial Fibrillation Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 No certificate has been signed by the a rector, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No After this certific funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pendina 1 X Natural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D66162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Edith N. Aniedobe, M.D. Silver Spring,MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 1 2008 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) JULY 2008 4:00 A 31 MARSHALL Physician Ρ. GEORGE 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S **Examiner** CAPITOL HEIGHTS 516 DATE LEAF AVENUE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, AUG 26 ^{Yea}r) 1927 7. Age (In yrs. last birthday) Sex 14 M 2 F 5. Social Security Number Days MARYLAND Hours **Funeral** Months Yrs. 215-26-2484 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinations to be nother traumatic. CAPITOL HEIGHTS PRINCE GEORGE'S Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 516 DATE LEAF AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Wes 2 □ No ARMY If Yes, Give Year or Dates: Black, White, etc. 11. Marital Status BLACK 1 ☐ Never Married 2 Married Specify: 1 ☐ Yes 2 🔼 No ğ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) PRIVATE PARTS SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CECELIA A. STEWART WILLIAM F. MARSHALL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 516 DATE LEAF AVENUE CAPITOL HEIGHTS, MARYLAND 20743 MARSHALL/WIFE MARY 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition CHELTENHAM, MARYLAND 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 8/11/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of europaid 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROADLANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE Due to (or as a consequence of): CHRONIC RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CONGESTIVE CARDIOMYOPATHY Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as e consequence of): Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death Day Year 3 Ectopic pregnancy 23h Was decedent pregnant Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown g \square Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Š Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

Physician /Medical Examiner

within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

has page director, this funeral (After

Be

Medical

Division of Vital Records, P.O. Box 68760

Hospital or Attending

within 24 hours arrest To the Funeral Director: Af

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2基No

25. Was case referred to medical 1K∏Yes 2 No Certification: To

27. Manner of Death

1 🔀 Natural

2 Accident

3 ☐ Suicide

5 ☐ Pending investigation

Hospital:

1 Inpatient Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

itle of cestifier 29b. Signature

29c. License number D32261

29d. Date signed (Month, Day, Year) JULY 31, 2008

no completed cause of death (Item 23a) (Type, Print)

RICHARD SELDMAN M.D. 9500 ANNAPOLIS ROAD # A-4 LANHAM, MARYLAND 20706

State Registrar

32. Registrar's Signat 31. Date filed (Month, Day, AUG 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:20AM **Physician** SARAH BELLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard County 8. Date of Birth (Month, Day, Year)
Time 13,1922 DC 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 579-30-2146 86 Director Usual Residence of Decedent 10a State 10b. County death with the Marylan 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exarciner must be notified at Howard County Md Ellicott City 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5320 Dorsey Hall 21042 USA items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "-- any injury or other traumotical." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21 No If Yes, Give Year or Dates: Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Jones Bernard Burruss Sr ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783Cornelius Moses Jr. (Son) 2801 Beaver Lodge Court, Adelphi Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🙀 Burial 2 ☐ Cremation 3 🗆 Removal from State :08/05/08 Landover Maryland Harmony Mem Park 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility Signature of Funeru ervice Licen 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part 1. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death) ter the disease, or o heart failure. List o Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line Physician ENO Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ed by the a detached f 9 🗀 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 1 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of After t 28d. Describe how injury occurred or Attending s after dec. 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29 2008 KENNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year) 32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Irvin Nichols 3008 illiam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** toio Health Care System If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 10 M 2 F Months Days Hours 218-24-4088 MD 02/13/1903 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 2180 Church by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1943-1944 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify 3 ₩ Widowed 4 □ Divorced act Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) Eastern Shore State College (1-4or 5+) dical 12 Mο 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Irvin Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Health a Eugene Nichols/ 20a. Metylod of Disposition Unit#15 Berlin MD21811 Street Department of Hea. Important: If item 27 any injury or other once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Hurlock 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Unknawn</u> Memisouria /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the innertal director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 Yes 2 No 3 Probably 4 nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie sura

State

Nichols

Name Known To Mysician.

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Health Care System 08-05594

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	ealth and Mental	Hygien

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E.,	neral	5	. Social Security Number 6. Sex 7. Age (In yrs. last birthd			AM/DD/YYYY) 9. E	Birthplace (State or eign
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	any	_	0a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1 Yes 2 X No
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Mary lar	28a-f show	윉	0e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
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212 uld be	mark e ever	0	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or	Rural Route Number	er, City or Town, St	tate, Zip Code)
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/ 2 6 3 3 8 9 , MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland	Healt item		ZUA, MIELIOU DI DISPOSITION	Disposition (Name of cemetery, y or other place)	Date	20c. Location - City	or Town, State
Baltimore, MD 21215-0036	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner must		1 XBurial 2 Cremation 3 Removal from State Ebene	zer AME Church	7-28-08	Gales	ville, Md.
Baltin permit. P	artme ortar	+	21. Signature of Funeral Service Licensee	Milliame 最色色层多of BoilitSOn			
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	sician	T	23a. Part / Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t, Shock, or fleat	Between Onset and Death
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Box	the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown	the wederlying agree given in Part I	23e Did tot	pacco use contribu	te to the cause of death?
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Division	or At fter d Direct in by	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.	or Town, S	tate) NB I-8	3 South of arks, MD
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1110	,		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
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pu	be filed stal Hygid of other avant, I	Be	17. Father's Name (First, Middle, Last)						18. Mother's Na	,			
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	d 2 fr		Betty May Parker	(wife)			4					ace, MD 2	
Baltimore,	S T T		20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □ F	lemoval from State				ame of other place	1	Date		. Location - City or T	
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Box (an/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		ath 3.□	Ectonic	pregnancy				23d. Date of deliv	•
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Division	f or Attanding after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.		, farm, str	eet, facto	ory, office			tion (Street or Town, S	t and Number or Rui tate)	ral Route Number,
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	2+		30. Name and address of person who c		ath (Item 23	a) (Type,	Print)	ave.	Harne	daga	a(2.	md 210	78
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Parker, Button

			1- For State of Maryland / Depar Registrar Cert	tment of Health and Mificate of Death	lental Hygie	ne _{No.} 2008	26218	
	Physici		1. Decedent's Name (First, Middle, Last) Mary C. Pruitt		2. Date of Death July 29,	Day 2008 Year	3. Time of Death 12:15 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	.	4c. County of Death	-	
			Sacred Heart Home	Hyattsville		Prince George's		
A.	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 7/14/19]		ace (State or Foreign ry) ngton, D.C.	
	yland low at		10a. State 10b. County 10c. City, Town or Local	ation		10	d. Inside City Limits	
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	or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?	
	s 23a	ral	5805 Queens Chapel Road	20782	- A- V	U.S.A.	n ladion	
396	within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☑ Yes 2█ No <i>Specify:</i>	Rican, etc.)	Black, White, e		
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Maryland 21215-0036	should be and Menta marked	ဥ	John H. Baciglupe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Number or Rura	ne Smith	ity or Town, State, Zin	Code)	
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ore,	es 1 a of Hea item		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or To		
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Baltimore,	permit. Pag Department Important: I any Injury o		N // D/ /2	Name and Address of Facility		4739 Balti	more Avenue	
_	Q = # 9	. 03		sch's Funeral Hom				
	Physician /Medical		23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Appendix Pertensive Card Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
8760,	rate be executed by sician and the burial-transit and the burial-tra	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Coronary Artherose Due to (or as a consequence of).	clerotic Disease				
.O. Box 68	death certific e attending p d for use as	Physician/Med		ctopic pregnancy Other (specify)		23d. Date of deliver	y Day Year	
rds, P	w requires that the d been signed by the should be detached	d by Pł	Part II. Other significant conditions contributing to death but not resulting in the und Progressive Cognitive Decline	erlying cause given in Part I.		co use contribute to th	e cause of death? ably 4 □Unknown	
or Vital Records,	The lar ate has page 2	Completed by			24a. Was an autopsy performed	prior to con death?	osy findings available of appletion of cause of	
Vita	Physician: The this certificate all director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		02020	
or	Physic this c	P	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			e 6 □Other (Specify)	
on	ding I	ijon:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred		
Division	il or Attending after death. I Director: Afte d in by the fune	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversal manner stated.	occurred at the time, date and place, stigation, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)	
			· X-X, V	D51122		July 30, 2	008	
R	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr					
	Sta	te	31 Date filed (Month Day Vear) 32 Registrar's Signature	St., N.E., Washi	ngton, D.	C. 20017		
	Registr		AUG 0 1 2008 See by force					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician $A^{\,\mathsf{M}}$ Dona1d 30 2008 H. Reddick Ju₁y 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buckingham Choice Buckeystown Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Oct. 18, 1927 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 80 Wisconsin Director 173-20-7104 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Frederick Adamstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. Specify: \$ WW II White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctor of Education Public Education 12 should be filed whand Mental Hygies Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be other traumatic P Reddick Madeline Yager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sh if Health ar Jean Reddick/Wife 3200 Baker Circle, Adamstow, MD 21710 permit. Pages 1 a Department of Hex Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Stauffer Crematory 8/1/2008 4 Donation 5 Dother (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA Signature of Funeral Service Licensee uh 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part. They he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Gronary /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058726 Var -30-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000-D Venture Ct - Yvette Warrenmo - myersville mo 31. Date filed (Month, Day, Year) 31 2008 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Beall <u> 2008</u> Maa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Battimare Universit enter 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. **S**ex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2KM 212-54-1197 Director 61 April 22, 1947 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedical Examble must be notified at Director 1 ☐ Yes 2 ☐ XNo Maryland Montgomery Brinklow 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Rivermist Court 20862 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: þ Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any Injury or other transmitted. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur Beall Dorothy Hohman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Rohrbaugh/Husband 1001 Rivermist Court, Brinklow, MD 20862 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Aug. 4 Donation 5 When (Specify) entembment 2008 f Heaven Cemetery 2008 | Silver Spri 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. Silver Spring, Maryland 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
\$\int \(\mathcal{U} \) C \] Immediate Cause (Final disease or condition resulting in death) **Physician** tungal Preumania /Medical Due to r as a consequence of) Examiner Myeloma Sequentially list conditions les a consequence of) d any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Examir and burial-tra Due to (or as a consequence of) attending physician for use as the hirial Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Ö 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s performed certificate 1 ☐ Yes 2: No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

State Registrar Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ko

31. Date filed (Month, Day, Year)

00

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** JULY 31. 0400 м RONALD ERIC SUMMERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 8. Date of Birth (Month, Day, NOV . 7, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 X M 2 □ F 214-42-2961 WASHINGTON, DC 1943 Vre 64 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND PRINCE GEORGE'S CO GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 R RIDGE ROAD 20770 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2**X** No Š Specify. 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF CARPENTER EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL D. SUMMERS LILLIAN MOYERS other traumatic ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; if Item 27 is
any Injury or other trau 57-R RIDGE ROAD, GREENBELT, MARYLAND MARSHA SUMMERS, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State STAUFFER CREMATORY 8/1/2008 FREDERICK, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Filmeral Service Licenses 7606 Old National Pike, Boonsboro, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. P. t1. En he disease, shock, owneart failure. L Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗌 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Unitural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) e and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#31perFCHD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death William Richard Stratton 27, 2008 5:40A.M July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Nursing & Rehab Montgomery Village Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 25, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 199-12-1512 81 Pennsÿlvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10315 Bethesda Church Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 TXYes 2 □ No If Yes, Give WWII Year or Dates: WWII 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Law Stratton Elizabeth (NMN) Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 Lois A. Stratton - Wife 10315 Bethesda Church Road, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Damascus Methodist 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31/08 Damascus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of uneral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for each o accident Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 □Yes 25. Was case referred examiner? 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death 1 Natural 5 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Physician /Medical Examiner The law requires that the death certificate be executed and

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Monee.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

the within 2 To the I

/Medical

burial-transit attending physician for use as the buria use as ned by the a certificate has been signed by rector, page 2 should be detacl

Examiner Physician/Medical 2 Completed Be ၉ Certification:

ours after death.

eral Director: After this certific filled in by the funeral director, 24 hours a

154

State Registrar

Medical

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 9608

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat M.D.

and manner stated.

10110 Molecular Drive, Rockville, Maryland

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

29b. Signatur

4 ☐ Homicide

(Check only one)

32. Registrar's Signature

6 □ Could not be

of certifier

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 5 per fh g885 11-5-08 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 26223 1 - State Registral Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** July 29 2008 2:00 a^M Russell E. Shaffer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Sun Valley Assisted Living Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 20 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F Yrs. 89 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD Carroll Westminster 1 ☐ Yes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1820 Stone Chapel Road 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 IIWW 1 ☐ Yes 2XNo Specify δ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Post Office Rural Letter Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miriam Sheets George A. Shaffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1736 Ridge Road Westminster, MD 21157 Thomas Shaffer/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08/01/2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Fune and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Threnu **Physician** /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 26 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe cate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Street (Specify) Living 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospitai Certifying Physician: To the best of my knowledge wath occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination appear investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated. To the certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title WJL IOTIVA ompleted cause of death (Ite 23a) (Type, Print) 30. Name and address of person who Ursil De Pr 31. Date filed (Month, Day, Year) State

Registrar

JUL 3

			For State	State of M	Marylan		artmen rtificat			l Mental H		0000	0.6	0.01
			Registrar 1. Decedent's Name (First, Middle,	l act)			uncai	e or D		2. Date of D	Reg. No.	2008	3. Time	of Death
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	Examin		4a. Facility Name (If not institution,	-	er)		,		ocation of De	ath		County of Death		
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ŀ	Funeral Director		5. Social Security Number 222-12-7822	**	84	last birthday) Yrs.	Months	Days	Hours Mi		Day, Year) -192	3 Beli	olace (State otry) Veder	e, DE
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fueeral Service	censee /	1100	1/2	he H	ouse 0use . 35	of Facility W	right N	orti	ary 1980	2	
i)			23a. Part1. Enter the disease, or c shock/or heart failure. List o	omplications that cause on each	sed the deal	n. Do not ent	er the mod	le of dying	, such as card	liac or respiratory	arrest,		Approxima	ate etween
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B0	death certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth 4□Pregnan	h 2 ☐ Feta	aldeath 3∐	Ectopic p					23d. Date of deli Month	very Day	Year
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o u	ing P		27. Manner of Death 1 Natural 5 □ Pending		Injury <i>Day Year)</i>	28b. Time o Injury		28c. Injury Work		28d. Describ	e how inju	ry occurred		
<u>S</u>	ttend death. stor: /	cati	2 Accident investiga 3 Suicide 6 Could no	ot be 28e Place of	injury - At h	ome farm str	M reet factor		′es 2 No	28f Location	(Street ar	nd Number or Ru	ral Route Nu	umber.
Division or Vital Records, P.O. Box	al or A s after o	Certification:	4 ☐ Homicide determin	ed building	, etc. (Speci	fy)	cot, idotoi	y, omoc			own, State		a, , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basi and manner	is of examina	owledge, deat ation and/or in	h occurred evestigatio	at the tim	e, date and pla pinion, death o	ace, and due to to ccurred at the time	ne cause(s ne, date an) and manner as d place, and due	stated. to the cause	∍(s)
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			br. n. Acr	1 12 1	19			Dog	6573	.3		7/31/3	વ	
•	3		30. Name and address of person w				Print)	(TDE	ET C	vita 21	\$ <i>I</i> =	ELKTON		1921
; M	Sta	ite	NARAYANA R 31. Date filed (Month, Day, Year)	₫ 32. Reg		ature			-121 3	-12 3				
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2008 26225

reg	ory M. Smith		State of Maryland / Department of Heal For State Certificate of Deat		ygiene Reg.	No	
	°hysicia	_	egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
i e	Examir	er	Gregory Michael Smith		Month Di August 3, 20		2115 hrs
		4	a. Facility Name (if not institution, give shoot and transport	Town, or Location of Death ge Park		4c. County of Deat Prince Georg	
			0120 40th Avenue ii 007	er 1 Year If Under 24Hrs	8. Date of Birth(MM/DD/YYYY) 9. Bi	
	Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 19 Yrs.			Forei	ountry) Wash. DC
		-	Usual Residence of Decedent				10d. Inside City Limits
	v any		10a. State 10b. County 10c. City, Town or Location				1 X Yes 2 No
1	Maryland 28a-f show d at once,	호	Md Montgomery Bethesda	o Code	10g.	. Citizen of What Co	
0	ith the Maryland 23a or 28a-f sho notified at once.	Director	noe. Street and rumbor			U.S.A.	
7	vith th s 23a		14 Martial Status 12 Was Decedent Ever in U.S. 13 Was Deced	ent of Hispanic Origin? (S	pecify Yes or No-		erican Indian, Black,
1	leath v	Funeral	1 Never Married 2 Married 1 Yes 2XX No	fy Cuban, Mexican, Puerto	o Rican, etc.)		
	after of al", or	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify: Occupation (Give kind of	work dono	Specify: W	hite
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	orking life. DO NOT use ref	tired)	OD. Territy of Education	, massay
	36 hin 72 e. than '	Completed	2 Stude	ent		Education	n
	15-0036 filed within 72 hours after of 1 Hygiene. ed other than "natural", o t, the Medical Examiner of		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Ma		
	21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Stephen Douglas Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	E Luzab	eth Filip		ate. Zip Code)
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	e, ME and 2 s fealth at ttem 27 traums	ŀ	20a. Method of Disposition		Date	20c. Location - City	or Town, State
	nore ages 1 at: If				g. 8,08	Falls Chu	rch, Va.
	Baltimore, MC permit. Pages 1 and 2 sh Department of Health an Important: If item 27 injury or other trauma	ŀ					
_4	W FYE		23a. Part I. Enter the disease, or complications that clused the death. Do not enter the mode	Visconsin Av	e N.W. Wa	shington	DC 20016 Approximate Interval
A	ysician /Medical		failure. List only one cause on each line.//		, , , , , , , , , , , , , , , , , , , ,		Between Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	toxication			
			Sequentially list conditions, b				
		ine	if any, leading to immediate cause. Enter Underlying Cause				
	d sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ledical E	M UNPENDED AMENDED 23a,27,28a-f, per	ME, g882 8/1	5/08 TT		
	60, ate be hysicia e buria	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	
	Box 6876 re death certificate the attending phy ted for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 5 Other (S		nancy	Month	Day Year
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	that the dended by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ng cause given in Part I.			e to the cause of death? Probably 4 Unknown
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	of V g Phy: fter thi	<u>1</u>	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day,Year) (Month, Day,Year)	28c. Injury at Work?		now injury occurred	
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	Division of Vital Rec pital or Attending Physician: The I ours after death. Therefore After this certificate I reral Director: After this certificate I filled in by the funeral director, page	tific	3 Suicide 6 X Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fact house	ory, office building, etc.	or Town, S	street and Number of state) 8125 4 Park, MD	r Rural Route Number, City 8th Ave.
	in so in	Medical Certification:	29a. Certifier 1 Continue Physician: To the best of my knowledge death occurred at	the time, date and place, a	and due to the caus	e(s) and manner as	stated.
4	To the Hos within 24 h To the Fun-	dica	Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at a complex of the property of the prop	my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	F. F.	Me	29b. Signature and title of certifier	29c. License number			(Month, Day, Year)
	(2)		anex	O.C.M.E.		August 4, 200	JO
			30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stree	t, Baltimore, MD 212	201		
		State	24 Date Fled (Marth, Day Vestle 32 Penistrar's Signature	6			
		etra	AUG 11 2008 Server D. August 15				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month ^{Day} 2008 July 28, 10:30A M Gladvs 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Brighton Gardens Assisted Living N. Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 4/23/1920 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Country) NY 1 □ M 2 X F Months Yrs 229-44-8759 88 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD1 □Yes 2 No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10804 Pebble Brook Lane 20854 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 □Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5+College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myer Schechter Anna Pearl Langenauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10804 Pebble Brook Lane Potomac MD 20854 <u> Mark Scher – Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns: 7/30/08 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD 22 Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Breast Cancer disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure Ducito (or as a consequence of) Hypertension Due to (or as a consequence of): Anemia 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 T Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 XNo 1 ∐Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident

Physician /Medical Examiner

physician and s the burial-tran

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within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

20

After thi funeral

director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

Examiner

Physician/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Exam of the confiled at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

1∐Yes 2∏vNo

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature ar

29c. License number D53691

29d. Date signed (Month, Day, Year) July 28, 2008

ss of person who completed cause of death (Item 23a) (Type, Print)

MD 6320 Democracy Blvd Bethesda MD 20817 Ajay Reddy

State Registrar

31. Date filed (Month, Day, Year) 31 JUL 2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) J_{uly}^{Month} 27, Day 2008 Physician 7:45 A M Barbara L. Schneider /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rethesda Suburban Hospital Date of Birth (Month, Day, Yea June 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) Min. 1 M 2 F Months Days Hours New York 1935 73 078-28-3424 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 10301 Grosvenor Place #310 Funeral 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 🏻 No Specify Specify ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public School School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ever Margaret Gottlieb Louis Weinstein ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 10301 Grosvenor Place #310 Rockville MD 20852 nt of Health a : If item 27 is Milton K. Schneider - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department of Important: If any Injury or once. Garden of Remembrance 7/29/08 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 32. Name and Address of Facility
The Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypotension Physician /Medical Due to (or as a consequence of): Examiner Ventricular Fibrilation Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of : Physician/Medical Examiner Coronary Artery Disease law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Acute Renal Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 XNo 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 □XNatural 2 □ Accident 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely

10

Registra DHMH 17 Rev 1/2001

State

29b. Signature and title of certifle

31. Date filed (Month, Day, Year)

Sima Nourani Zenuz MD 8600 Old Georgetown Road Betehsda MD 20814

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed rau e of death (Item 23a) (Type, Print)

2008

		1 - For State Registrar AMEND#200per FF	State of Marylar		artment of rtificate of		d Mental Hy	/giene	10 2022		
Physic /Med		1. Decedent's Name (First, Middle, Las Remberta Rosari	t)			-	2. Date of De Month July		ar 3. Time of Death 3:13 p M		
Exami		4a. Facility Name (If not institution, give Montgomery General	al Hospital		4b. City, Town,	or Location of Do		4c. County of D	Death		
Funeral Director		5. Social Security Number 6. Sec. 267–95–1168 Usual Residence of Decedent	7. Age (<i>In yrs.</i> ☐ M 2 🖾 F 79	last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Di	rth ay, <i>Year)</i> 9. 1928	Birthplace (State or Foreign Country) Cuba		
he Marylan 8a-f show	Director			y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No		
ath with the 23a or 2		10e. Street and Number 400 London Terr	ace		10f. Zip Code	2085	3	10g. Citizen of What USA	,		
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantine must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2克No If Yes, Give Year or Dates:	1	Was Decedent of I f Yes, specify Cub I ☑¥es 2☐ No		(Specify Yes or No erto Rican, etc.)				
21215-0036 d within 72 hours aft giene. sr than "naturai", or	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give i life. E	lent's Usual Occup kind of work done DO NOT use retire memaker	during most of u	vorking	16b. Kind of Business/Industry			
Maryland 2 d 2 should be filed th and Mental Hyg I? Is marked other traumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Alberto Riveron		1101	memaker		lame (First, Middle,	Own Home Maiden Surname) guez			
e, Mary 1 and 2 sho 4 ealth and 1 an 27 is m		19a. Informant's Name/Relationship (Ty Edilberto J. Silv	a/Son	17529	9 Gallagi	and Number or her Way,	er, City or Town, State MD 20832	e, Zip Code)			
Baltimore, permit. Pages 1 ar Department of Hea Important: if item 3 any injury or other other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	demoval from State	emetery, crem	sition (Name of natory or other place eaven Cen Name and Addre	metery -	Date 8-4 Aug. 2, 2008	20c. Location - City Silver Sp	or Town, State		
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line. Diffuse (or as a consequence of the	. Do not ente	Univer	rsity Bl	vd. W.	rrest,	ing, MD 20901 Approximate Interval Between Onset and Death		
icate be executed physician and the burial-transit	dical Examiner	Severe Hypoal bunning									
ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ac. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🔲	Ectopic pregnancy Other (specify)	4		23d. Date of delivery Month Day			
w requires that the de sheen signed by the a should be detached f	þ	Part II. Other significant conditions con	tributing to death but not resul	ting in the und	derlying cause give	en in Part I.			to the cause of death?		
ician: The law certificate has b ector, page 2 sh	e Completed	25. Was case referred to medical					24a. Was a autops perfor	sy prior to med? death? 2 2 No 1 □ Ye	autopsy findings available completion of cause of		
iding Physician; th. After this certific funeral director,	tion: To Be	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 E	R/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 Nursing		ence 6 Other (Sp ow injury occurred	ecify)		
itai or Irs afte ral Dire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)		t, factory, office	∕es 2□No	City or Town				
the Hosp thin 24 hou the Funer	Medical	one)	cian: To the best of my knowler: On the basis of examination and manner stated.	ledge, death o	occurred at the tim stigation, in my op	ne, date and plac pinion, death occ	ce, and due to the c curred at the time, d	cause(s) and manner a late and place, and du	as stated. le to the cause(s)		
P ₹ P 8		29b. Signature and title of certifier			29c. License	529		9d. Date signed (Mon 7/29/2			
Stat		30. Name and address of person who com MARIA VILLANUE V 31. Date filed (Month, Day, Year)	HOSPIT	TALIST		PHILIP	DR OLN		70832		

State Registrar

JUL 3 1 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JULY 30, 2008 ear 1801 KENNETH LEE STOTTLEMYER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH 9, 1938 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 M M 2 □ F Months Days MARYLAND 70 215-36-7132 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1√2 Yes 2 □ No HAGERSTOWN MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21740 U.S.A. 49 RANDOLPH STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOODWILL INDUSTRY CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HATTIE BUTTS STACY STOTTLEMYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21740 49 RANDOLPH STREET, HAGERSTOWN, MARYLAND CATHERINE STOTTLEMYER, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/2008 BOONSBORO, MARYLAND BOONSBORO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Fyneral Strice Licensee 7606 Old National Pike, Boonsboro, MD 21713 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease shock, of heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary 10 years disease or condition resulting in death) 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arling Disease 3 Probably 4 □Unknown 1 Tyes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical Examiner

attending physician

has

Division or Vital Records,

Hospital or Attending

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within 24 hours at To the Funeral C completely filled i

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28a-f show

Director

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Completed

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Important: If iter
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2 should be fi. and Mental H

Baltimore, Maryland 21215-0036

Physician/Medical the as þ Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner?

2 Accident

3 Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of co

29c. License number

30. Name and address person who completed cause of death (Item 23a) (Type, Print) app ans Ad Boonshow Mo

State Registrar 31. Date filed (Month, Day, AUG 04 2008



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Funeral		5. Social Security N		S. Sex	F1.	7. Age (In y		day) I	f Under 1		If Under Hours	24 Hrs. Min.	8. Date of E	Dav. Year	·)	9. Birthpl	lace (State o	r Foreign
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ages nt of h r if ite			☐ Cremation 3		al from S		Place of D cemetery, nelte	cremate	ory`or othe	r place	e) Comu		Date 5/08			- City or To	wn, State Mary	.land
permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland begraturent of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	1	4 ☐ Donation 21. Signal of Fi	5 ☐ Other <i>(Sp</i>					122	lame and				3700	CITE	STLE		20011	
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physic the b	d																	
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or Arren Ifter deal Director: in by the	lica	2 Accident 3 Suicide 4 Homicide	6 Could no	t be	. Place	of Injury - At	home, farm	ı, street,			00 -		28f. Location			ber or Rura	l Route Num	ber,
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To the Topsplat or Attending Prystician. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: O	n the b	best of my kasis of exam ner stated.	nowledge, oination and/	death or or inves	ccurred at stigation, in	the tim	ne, date ar pinion, dea	nd place ath occur	, and due to ti red at the tim	ne cause e, date a	(s) and m nd place,	nanner as s and due to	tated. the cause(s)
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(4)		30. Name and add	ress of person w	ho complete	ed caus	e of death (I	tem 23a) (Ty	ype, Prir	nt)	1×1	bone	R	1 Hyo					
State	~	31. Date filed (Mor		1	32. R	egistrar's Sig		•		J-0								-
Registra	24	AUG U	T 5000	Blow	"	D A												

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day OSWALD EUGENE UTTERBACK JULY 28 2008 1:53P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F 218-05-2197 89 Oct 30 1918 Brunswick, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Knoxville 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19332 Keep Tryst Road 21758 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Dept. of Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William W. Utterback Emma Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June L. Utterback, Wife 19332 Keep Tryst Road, Knoxville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Mark's Cemetery 7/31/08 Petersville, MD 22. Name and Address of Facility John T. Williams Funeral Home Owner 100 Petersville Road, Brunswick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo Cardial disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be

law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital Hospital or Attending Physician:

Examiner burial-transit signed by the attending physician I be detached for use as the buria been signated by should b has page 2 certificate this funeral (After ours after death.

leral Director: A
filled in by the fu within 24 hours a

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exercises.

Physician

/Medical

/Medical

Director

by Funeral

Completed

Be

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Sequentially list conditions, if any leadiny to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing þ Completed 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be Certification: To 27. Manner of De th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Medical

DO064568

08

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DECHOSA Paranguil, Ul 21716 610 Ninth

State Registrar

10

31. Date filed (Month, Day, Year)

NIVIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** EWORTH 0. VOGLEZON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y NOV 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 9^{Year)} 1937 Days Min. 1[XM 2□ F Months Hours Yrs. GAYANA, S.A. Director 058-64-3635 70 Usual Residence of Decedent show 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mertal Hygiene. Important: If Hem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "bedical Examine must be notified. Director 1 X Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13212 KEVERTON DRIVE 20774 GAYANA, S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🛣 No \$ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th ELECTRICIAN PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REGINALD VOGELZON ELIZABETH DESILVA ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13212 KEVERTON DRIVE UPPER MARLBORO, MARYLAND 20774 CLAUDETTE VOGLEZON/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/8/2008 BRENTWOOD, MARYLAND LINCOLN CEMETERY 21. Signature of Fureral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or compilentions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ONGESTIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ARDIO MY 0 and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Junknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s 24a. Was an autopsy performe certificate 1 □Yes 2X No 2 XNo 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 □Yes 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

oglezon, Eworth

Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.
 Euneral Director: A letely filled in by the fu

Medical completely within 2

30. Name and address of person wi Kevin Ertan

29b. Signature and title of certifier

29a. Certifier

(Check only one)

pleted cause of death (Item 23a) (Type, Print) 8118 Good Luck Rd., 32. Registrar's Signa

31. Date filed (Month, Day, Year) AUG 0 1 2008

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D61552

29d. Date signed (Month, Day, Year) 07-30-08

Carham, MD. 20706

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DΗ	łМН	17	Rev	1/2	001

		State of Maryland / De	epartment of Health and N	•	•
		a Pol	Certificate of Death	Reg. No	0000 00000
Physici /Medic		1. Decedent's Name (First, Middle, Last) Drycilla Elizabeth Wri	ght	2. Date of Death Month Day	2008 10:20AM
Examin	ner	4a. Facility Name (If not institution, give street and number) Coastal Hospice at the Lake	4b. City, Town, or Location of Death		County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Director		218 - 20 - 9039 1 M 2 F 8 Yr	s. Worths Days Moule Will.	May 24, 193	
ryland how		10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
the Ma 28a-f s	ecto	MD Wicomico Salie 10e. Street and Number	soury	10- 0	1 ∰Yes 2 No
3a or	Funeral Director	1101 Lake Street	10f. Zip Co'de		izen of What Country?
tems 2	uner	11. Mantal Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show warly injury or other traumatic event, the Medical Examiner must be notified at ance.	ρ	1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
in 72 h 1 "natu ledical	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	kina	ind of Business/Industry
giene. grene. er thar	mo.	Elementary/Secondary (0-12) College (1-4or 5+)	-ibrarian		inty schools
and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' ner traumatic event, <u>the Me</u>	To Be (17. Father's Name (First, Middle, Last) Saint Clair Wright	1.	ne (First, Middle, Maider	Surname)
2 shour and M	-	19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Street and Number or Ru	ral Route Number, City o	or Town, State, Zip Code)
s 1 and if Health Item 27 other tr	-	20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place)		City or Town, State
Pages ment of I ant: If Ite ury or of		Bunal 2 Cremation 3 Hemoval from State		31/08 Fr	uitland, MD
permit. Departimont any inj	J	21 Signature of Funeral Service Ligensee	22. Name and Address of Facility		ar wisabella st.
		23a. Part1. Prim the dist ase, or compil ations that caused the death. Do no shock, or heart failure. List only one cause on each line.	Bennie Smith Funer t enter the mode of dying, such as cardiac		Approximate
Physician		Immediate Cause (Final disease or condition CARCINDWA	OF LUNGS		Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of)			2/# 4 = 7
p #	iner	Sequestidary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	each to 12 Tuch	The state of the	7/3/1/43/5
be executed sician and bunal-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C	:		
ate be nysicial he buri	cal	d			
leath certificate attending phys for use as the	/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 poinths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 25b. Was decedent pregnant in the past 12 poinths? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
res that signed to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		use contribute to the cause of death?
w require been significants	eted				No 3 Probably 4 Monknown
	Completed			24a. Was an autopsy performed? 1 Yes 2 H	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 → 10
yslclan; s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Ampatient 2 ☐ ER/Outp	Other:	th Check onl one	S Cother (Cracife)
dIng Phys h. After this funeral dir		27. Manner of Death 127. Natural 5 □ Pending 128a. Date of Injury (Month, Day Year) Inju	ne of 28c. Injury at	ome 5 Residence 28d. Describe how inju	
ttendli death. ctor: A / the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be 280 Place of injury. At home form	M 1 ☐ Yes 2 ☐ No	20f Location (Street a	and Alicenhaus as Count Davide Microbau
tal or A rs after al Director ed in by	Certification:	4 Homicide determined building, etc. (Specify)	i, street, factory, office	City or Town, Stat	nd Number or Rural Route Number, e)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the cause(surred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
To within	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
38		30. Name and address of person who completed cause of death (Item 23a) (Ty		all in	21/22
Sta		31. Date filed (Month Day, Sac) 2008 32. Egistrar's Signature	A-m	JANS BUIL	y me vive
Registr MH 17 Rev 1/2		Japane Jo			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , Day 2008 **Physician** Kathleen July 27, Τ., Wyatt 8:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury 512 Truitt Street Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 217-30-8867 73 Director 5/17/1935 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience on the traumatic event, the Medical Experience on the protection. Director 1 ¥ Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Truitt Street 21804 USA Funeral 12. Was Decedent Ever in U.S. Was Deceu Armed Forces? ✓ Ves 2 🔀 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Highway Elementary/Secondary (0-12) College (1-4or 5+) secretary Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Evan Livingston ဂ္ Edith Derby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Holland/daughter 1507 Laurel Dr., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/1/08 Salisbury, MD 21. Signature of Funeral Service L 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) Z yrs /Medical Examiner Cordiovascular Ischemic 10 yrs Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate performe 1 ☐ Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred s after deu. 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical etely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 024986 16.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reilly 560 RIMPSILE Pr. B101 mo Salisbury And 2180 31. Date filed (My) Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1735M Olan J. Williams, Jr. 2008 Jul /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death , Examiner Vicimica Salisbur REGIONAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 62 Director 215-44-6289 Oct. 17, 1945 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Exeminar must be notified at 1 ☐ Yes 2 XNo Director MD Wicomico Hebron 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21830 U.S.A. Funeral 9099 Goldfinch Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items, 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1964-1 ☐ Yes 2 🛣 No ģ Specify: white 3 Widowed 4 Divorced "natural" 1968 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Coil Shear Operator Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Cork & Seal Manufacturing 12 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental 1 and 2 should be Virginia Cline Olan J. Williams, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is Donna L. Williams 9099 Goldfinch Court Hebron, MD permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr
once. (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva07-29-2008 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 19940 13 East Grove Street Delmar, DE Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart f sease, or complications. List only one ause on each line Immediate Cause (Final disease or condition resulting in death) Seps es Physician /Medical Due to (or as a consequence of): Examiner Perforted dooderel Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No signed by the detached 9 Unknown 9 Hinknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes or Attending Physiclan; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To s after death. 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Imp IVA

State Registrar 31. Date filed (Month, Day, Year) JUL 29

29b. Signature and title of certifier



who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 1, Day 2008 **Physician** Robert Edward WOLFE 7:59 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 South Walnut Street Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 21,1933 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 X M 2 □ F 75 220-26-5098 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination must be motified at Be Completed by Funeral Director Maryland Washington 1x Yes 2 □ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 South Walnut Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ★Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: white 1 ☐Yes 2 X No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) unknown College (1-4or 5+) custodian bowling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be of Health and Mental Charles P. Wolfe Margaret J. Whalen ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Shaw - daughter 223 Bryan Place, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Į. Department of important: If it any injury or o August 5 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown nis certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Division of Vital Records, 2 1 Nes 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature a d title of certifier 29c. License number 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) 5H1+1 435 hal 122

DHMH 17 Rev 1/2001

State

Registrar

1. Date filed (Month, Day, Year)

AUG 05

2008

ORIGINAL

32. Registrar's Signature

1742

			1 - State Registrar		artment of Health and artificate of Death	Reg	ene . No. 2 0 0 8	26237					
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Timothy F. Whistler			2. Date of Death Month July	Day Year 29 2008	3. Time of Death 7:45 A M					
1	Exami		4a. Facility Name (If not institution, give street and 1605 Spence Street	d number)	4b. City, Town, or Location of Dea	th	4c. County of Death						
	Funeral Director		5. Social Security Number 6. Sex 13–62–7359 1X M 2	7. Age (In yrs. last birthday) F 54 Yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yo	9. Birthpl Coun						
			Usual Residence of Decedent 10a. State 10b. County			Dec. 22,							
	with the Marylan a or 28a-f show Lear cillical at	ctor	Maryland	10c. City, Town or Le Baltimore	ocation			10d. Inside City Limits . 1. ✓ Yes 2 ☐ No					
	ath with the \$23a or 28	al Director	10e. Street and Number 1605 Spence Street		10f. Zip Code 21 230		Citizen of What Count						
9800	ours after de ral", or items Examiner n	d by Funeral	Arme 1 Never Married 2 Married 1 Yes	es 21XINO	Was Decedent of Hispanic Origin? (stiff Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ₺ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify: Whill	tc.					
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours at of Health and Mental Hygiene. If item 27 is marked other than "natural", or other traumatic event, the Medical Esp	Completed		ed) (Give	edent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	b. Kind of Business/Ind						
/land	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last) Clarence F. Whistler			me (First, Middle, Mai I Drury	den Surname)						
	and 2 sho ealth and I n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type. Print) Susan Stielper - siste	er 19b. Maili 2905	ng Address (Street and Number or R Tulip Way Mai	ural Route Number, C nchester,	ity or Town, State, Zip Maryland 2	Code) 102					
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation 2008 Hamp									
Balt	permit. Departi Import any Inj		21. Signature of Funeral Service Licensee	^ M01072 93	2. Name and Address of Facility Fig. 34 South Main Stro	line Funer eet Hamps	al Nome tead, Maryl	and 21230					
1	Physician /Medical	101.02	23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 2 Weky								
	Examiner	_		to (or as a consequence of):	HTN								
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of):		***************************************							
P.O. Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Funeral Director: After this certificate has been signed by the attending physician and nely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	in the past 12 months? 1 ☐ L 1 ☐ Yes 2 ☐ No 4 ☐ F		□ Ectopic pregnancy □ Other <i>(specify)</i>		23d. Date of deliver Month	y Day Year					
rds, P	quires that en signed k uld be deta		Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?					
Vital Records,	ician: The law requir certificate has been s ector, page 2 should I	Completed by	OF Warner of word have the			24a. Was an autopsy performed 1 □ Yes 2 □	prior to com death?	sy findings available pletion of cause of					
of Vil	Physician: this certific al director, I	To Be		☐ Inpatient 2 ☐ ER/Outpatier	Othori	ath <i>(Check only one)</i> Iome 5 Residence	e 6 ☐ Other (Specify)						
ion	nding F ath. r: After ie funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ate of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred						
Division	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, strillding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, St	t and Number of Rural fate)	Route Number,					
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the	Medical C	tollock only 12 Medical Examiner: On the	the best of my knowledge, deatle e basis of examination and/or in nanner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	a, and due to the caus urred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)					
	Within To th	Me	29b. Signature and the dispertifier	M)	29c. License number D 6 0 8 4 2		Date signed (Month, D	ay, Year)					
_	with	-	30. Name and address of person who completed c	ause of death (Item 23a) (Type,			-30-8						
	© Sta	te	VAIBHAV A PARE 31. Date filed (Month, Day, Year) 32			BACTIM	ere m	2/230					
	Registra	ar	JUL 3 1 2008	Registrar's Signature	radio								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26238

			- For State Registrar	Certificate or	f Death		Re	g. No.	
	Physicia	ın/ È	Decedent's Name (First, Middle,Last)				Date of Deat Month	Day Year	3. Time of Death
	1 Exami	ner	Dwyane L. Wilborne				August 4,		
			4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L Glen Burnie	ocation of Death		4c. County of Anne Aru	
	_		Baltimore Washington Medical Center		If Under 1 Year	If Under 24Hrs.	P Date of Bir	1	
	Funeral	1		n yrs. last birthday)		Hours Min.	Tan	1 1968	9. Birthplace (State or Foreign Country) Germany Badconstatt
	Director		219-02-4614 1XM 2F	40 Yrs	3.		Uall I	.4 1500	Badconsodo
	8		Usual Residence of Decedent 10a. State 10b. County 10b.	c. City, Town or Local	tion				10d. Inside City Limits
	w any		Maryland Anne Arundel	Glen Bu					1 Yes 2 X No
P.C.	faryland 28a-f show 1 at ouce,	ğ			10f. Zip Code		T ₁	0g. Citizen of Wha	at Country?
	Mary r 28a ed at	Director	10e. Street and Number		2106	1		USA	
y	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho		399 D Old Stage Rd. 11 Marital Status 12 Was Decedent Ev	or in 11 S	as Decedent of Hisp		ecify Yes or No		American Indian, Black,
19	ith wi	uneral	1 Nover Married 2 V Married Armed Forces?	if `	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White,	
	er des	<u> </u>	3 Widowed 4 Divorced If Yes, Give Year	No 1	Yes 2 X No	specify:		Specify:	Black
	5-0036 ed within 72 hours after tygiene. other than "natural",	호	or Dates: 15. Decedent's Education (Specify only highest grade complete)	eted) 16a. Decede	nt's Usual Occupati	on (Give kind of v		16b. Kind of Bus	iness/Industry
	2 hou "nat		Elementary/Secondary (0-12) College (1-4 or 5+)	during n	nost of working life.	DO NOT use reti	red)		
	thin 7 than than edica	힐	12th 2yrs	E	ntrepre				torial
	215-0036 be filed within ntal Hygiene. rked other tha	Completed	17. Father's Name (First, Middle, Last)		1		,	Maiden Surname)	
		Be	Ronald A. Wilborne			Shirle	-		
	21 nould id Me is ma tic ev	유	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street				e, Md. 21061
	MD and 2 sho alth and rm 27 is		Kamili Wilborne(Wife)	20b. Place of Dispo			Date Date		City or Town, State
	S La		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	crematory or c	ther place)				
	Page nent o		4 Donation 5 Other Specify:	реdar ні	11 Ceme	tery 8-	-11-08	Balti	more, Md.
	Baltimore, permit. Pages 1 at Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	2 10	mame a Reess 21 West	GH Ar	nanol	is. Md.	21401
			3a. Part I. Inter the disease, or complications that caused the						
	hysician Medical		failure. List only one cause on each line.						Death
	≟xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertens: Due to (or as a consequence)		sclerotio	c cardio	vascula	<u>r diseas</u>	e
			h	20					
		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the consequence).	uence of):					
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence)	uence of):					
	ited d ansit		events resulting in death) Last Due to (or as a consequence of the con						
	760, icate be executed sphysician and the burial - transit	/Medical	X UNPENDED X AMENDED 3 3	27, perME er, fill G882	88827861	5/ 10 8 TT			
	760, icate be physical the burn	Wed	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of	
	587 striffca ling p		23b. Was decedent pregnant in the past 12 months?	6.1-11		Ectopic pregn	ancy	Month	Day Year
	Box 687 e death certific the attending	sici	1 Yes 2 No 9 Unknown g Unknown	me or death 5	Other (Specify)				
	by the tched f	Physician	Part II. Other significant conditions contributing to death t	out not resulting in the	e underlying cause of	given in Part I.	23e. Did	tobacco use contr	ibute to the cause of death?
	P.O.						1Y	es 2 No 3	Probably 4 🗸 Unknown
	ords, w require s been sig	Completed by					24a. Wa		Were autopsy findings available
	Or law re has be 2 sho	g					per	formed?	prior to completion of cause of death?
	Vital Rec ysician: The his certificate director, page	5 			00.53	I Death (Ohea)	1 Yes	2 No 1	Yes 2 No
	tal cian: certif ector,	Be	25. Was case referred to medical examiner? Hospital:	a Taleno Lucio		of Death (Check Other: Nurs	ing Home 5	Residence 6	Other:
	Physic r this	阜	1 Ves 2 No Inpatien 27. Manner of Death 28a. Date of Injury	t 2 ✓ ER/Outpatie		ry at Work?		e how injury occur	
	ding Phy After tl	ᇹ	1 X Natural 5 Pending		· · · · ·	Yes 2 No			
	SiOl Viten death death ctor:	cati	2 Accident Investigation	ry - At home, farm, st			28f. Location	(Street and Numb	er or Rural Route Number, City
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl	Certification:	3 Suicide Could not be determined (Specify)	ry - At nome, lam, st	reet, ractory, chico	bunung, oto.	or Town		
	Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Continuing Physician: To the hest of my	knowledge death oc	curred at the time, d	late and place, ar	nd due to the ca	use(s) and manne	r as stated.
	the H hin 24 the Fl	Medical	one) 2 Medical Examiner: On the basis of exam	ination and/or investi-	gation, in my opinio	n, death occurred	at the time, da	te and place, and	due to the cause(s)
4	To Witl	Med	and manner stated. 29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ned (Month, Day, Year)
		_	1. Il Mala	·D	O.C.	.M.E.		August 5,	2008
			30. Name and address of person who completed cause of de	ath (Item 23a)					*
H	40		Russell Alexander MD. Assistant Medica		11 Penn Street	, Baltimore, N	MD 21201		
7		tate	31. Date filed (Month, Day, Year) ALIG 0 8 2008 32 Registrar	s Signature	mark a				
		strar	AUG 0 8 2008	J J J	ALC: UNIVERSITY OF THE PARTY OF			OCM	(E

08-05698										
John	C.	Watts								

hn C. Watts		State of Maryland /	•	tment of ificate of		and	Menta	al Hyg		leg. No.	20	08 26	23
Physicia edical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) JOHN C. WATTS							Date of Dea Month July 25, 2	ath Day	Year	3. Time of Deat 0430 hrs	th
		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital		41	c. City, To		ocation of		buly 20, 2	4c	. County of De		
/ Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. las	t birthday)	If Under	1 Year			8. Date of Bi		DD/YYYY) 9.	Birthplace (State or	
Director		578-19-8689 1X M 2 F Usual Residence of Decedent		18 Yrs.	Months	Days	Hours	Min.	JULY '	7, 1		CountrWASHIN	IGTON
w any				own or Location						 -		10d. Inside City	
ith the Maryland 23a or 28a-f show any notified at once.	ctor	10e. Street and Number	WAS	HINGTO	10f. Zip C	ode			1	10g. Citi	zen of What C		INO
ith the Mi 23a or 23 notified	l Dire	5005 CALL PL., S.E. #7				2001					TED ST		
er death wit , or items 2	Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year	X No	If Ye	Decedent s, specify Yes 2X	Cuban, N	Mexican, F		oify Yes or No can, etc.)	0~	White, etc	nerican Indian, Blac :. BLACK	k,
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tramatic event, the Medis - Examiner must be notified at once	eted by	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5-		16a. Decedent during mo	s Usual O st of worki	ccupation	n (Give kir OO NOT us			16b. I	Kind of Busine		
-0036 f within giene. ther tha	Completed	11 17. Father's Name (First, Middle, Last)				STUD 18		Name (F	irst, Middle,		EDUCAT :	ION	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Media	Be	JOHNNY DAVIS		T-0. 11 (1)			CYNTI	HIA	WATT	ΓS			
MD 2 Id 2 shoul- lith and M m 27 is m aumatic	5	19a. Informant's Name/Relationship (Type, Print) ROBIN I VAUGHN/AUNT								INGT	ON, D.	ate, Zip Code) C. 20019	
5 2 2 2 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	te cr	ace of Dispositematory or other AR HILI	er place)				Date			or Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. For a ture of Funeral Service Licensee	110.	Too N			4 F11/4 -	8/6/ CAP			ITLAND HARY HINGTON		0002
Physician		23a. Part I. Enter the disease, or complications that caused t failure. List only one gause on each line.	the death									Approximate Between Ons	
/Medical Fxaminer	3 17	Immediate Cause (Final Isease or condition resulting in death) a. Multiple Gunsho Due to (or as a conservation)										Death	
- 4	-	Sequentially list conditions, if any, leading to immediate Due to (or as a conse							_				
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executed in and il - transit	edical Ex	d. UNPENDED AMENDED											
760, cate be exe physician a		IF FEMALE: 23c. If yes, outcom	e of pregna	ancy			1	_		23	d. Date of deli		
Box 68760, e death certificate be the attending physic ed for use as the buri	Physician/M	past 12 months? 1 Live birth 4 Pregnant at t 1 Ves 2 No 9 Unknown 9 Unknown	ime of dea		al death er (Speci	3 <u> </u>	Ectopic	pregnand	Б у		Month	Day Ye	ear
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2 is 12 C	Completed							_	24a. Was auto perfe 1 V Yes	psy ormed?	prior deat		
tal Rectian: The	Be Cc	25. Was case referred to medical examiner?			26		of Death (C	Check on				100 2	
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ivision or Attending after death. Director: A	ation	1 Natural 5 Pending 2 Accident Investigation		0345 hrs			es 2 🗸 N	No	ubject sh				
Division ospital or At hours after duneral Directly filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injune 4 ✔ Homicide (Specify) Mul			t, factory,	office bu	ildıng, etc.	44			and Number of Camp Spring	Rural Route Numb	per, City
the Hos hin 24 h the Fur npletely	Medical (29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner:On the basis of exam											
To with To Con	Me	29b. Signature and title of certifier				License						(Month, Day, Year)	
		30. Name and address of person who completed cause of de	(Item 2	23a)		O.C.M	I.C.	-		July	y 26, 2008 		
2 3	Į Į	Russell Alexander MD. Assistant Medica	al Exami	iner 111	Penn S	treet, E	Baltimor	re, MD	21201				
St Regist	tate trar	31. Date filed (Month, Day, Year) AUG 0 1 2008 32. Registrar	s signarin	الكان									



OCME

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death

			1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death		
	Physici /Medio		Estellyn S.	Winebrenner					5/2008 Year	2:00 PM	
*.	Examir		4a. Facility Name (If not institution, give s		4b. City, Tow	n, or Location of Deatl	n	4c. County of Death			
1			Kensington Nursing	g & Rehab	Ke	nsington		Prince George's			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	If Under 1 Ye Months Da		(Month, Day,	Year) 9. B	rthplace (State or Foreign Country)		
	Director		5/8-20-0081	99	Yrs.		<i>'</i>	12/10/1	908 A1	abama	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits	
	laryla sho	៦	,							1XYes 2 No	
	the M	Director	MD Prince Ge	eorge's B	rentwo	Od 10f. Zip Cod	le .	10	0g. Citizen of What C	Country?	
	a or					101. ZIP 000		1.		odini y .	
	eath	era	3712 Webster Stree	2. Was Decedent Ever in U.	S 13	Was Decedent	20722	pecify Yes or No-	U.S.A.	nerican Indian	
	ter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☑ No			of Hispanic Origin? (S Cuban, Mexican, Puert	o Rican, etc.)	Black, Wh		
036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Madical Exeminer must be neithed at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2🎛	No Specify:		Specify:	White	
Ŏ	2 hou	Completed	15. Decedent's Educ	ation		dent's Usual Od			16b. Kind of Busines	s/Industry	
2	hin 7 e. an "n	ed.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	ne during most of wor tired)	king			
2	should be filed within and Mental Hygiene. s marked other than aumatic event, the Mental than aumatic event, the Mental than a management than the Mental than	5		2	Hom	emaker_			Own Home	2	
p	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, N	Maiden Surname)		
<u>Na</u>	should band Ment marked umatic e	၉	Rudolph Smith				Olive	Jones			
a	2 sho		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Str	eet and Number or Ru	ıral Route Number	; City or Town, State	, Zip Code)	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "social Exprine," and the natified at		Ida May Price, Dau				r St., Bre				
ore	les 1 of H if itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20b. P	lace of Dispo emetery, crea	sition (Name o natory or other	place)	Date	20c. Location - City of	or Town, State	
Ξ	Pages ment of I ant; If ite ury or of		4 □ Donation 5 □ Other (Specify)	Alexandr	ia, VA						
<u>a</u>	permit. Page Department Important; If any Injury o		21. Signature of Funeral Service License	e			dress of Facility			timore Avenu	
ш —	<u>6 9 5 9 9</u>		femol ble		G	asch's	Funeral Ho	me, P.A.	Hyattsvi:	11e, MD 2078	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ent	ter the mode of	dying, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death	
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-	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
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	ed sit	jue	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of).						
0	icate be executed physician and s the burial-transit										
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cian/Medical	d.								
×	eath certific attending p for use as t	N/W	IF FEMALE:	Bc. If yes, outcome of pregna	incv				23d. Date of d	olivery	
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g	uires n sigr ld be	d by	Dementia					1 □ Ye	es 2 No 3	Probably 4 🛭 Unknown	
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æ	he lav e has ige 2 t	ᇤ						autops perforn	y prior to ned? death	completion of cause of	
æ	ifficat or, pa		25. Was case referred to medical				26 Plans of Day	1 ☐ Yes 2 ath (Check only on		es 2 No	
Division of Vital Records,	or Attending Physician: The lafter death. Director: After this certificate him by the funeral director, page	o Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐	FR/Outnaties	nt 3 🗆 DOA	Otto		ence 6 □Other (S _i	agaifu)	
ō	a Phy eral c	Ë	27. Manner of Death	28a. Date of Injury	28b. Time o		njury at Vork?		ow injury occurred	Jeony)	
<u>o</u>	nding th. T: Aft	gi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		work? 1 □ Yes 2 □ No				
N N	Attend	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he	me, farm, str	eet, factory, off	ce			Rural Route Number,	
	s after s after s all Dir	Certification: To	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical (ician: To the best of my kno er: On the basis of examina and manner stated.							
	To the within 2 To the complex	Me	29b. Signature and title of certifier		<u></u>	29c. Lic	ense number	2	9d. Date signed (Mo	nth, Day, Year)	
			I chelen	M	ν		D0064624		July 31,	2008	
			30. Name and address of person who cor	npleted cause of death (Item	n 23a) (Type.		00004024	-	Jury Jr,	2000	
2	14/			10901 Connect			nsington.	MD 20895			

State Registrar

31. Date filed (Month, Day, Year) AUG 0 1 2008

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month AULINE 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION HOSPITAL ECKTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Months Days Hours WOST 1 ■ M 2 🗗 F 235-44-6115 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No NORTH EAST MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? marked other than "natural", or Items 23a or POINT URKEY USA 1400 21901 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 1 No Maryland 21215-0036 þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HomE Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be DONALD FIELDS MARGARET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S RO. NORTH E tem 27 is 1400 TURKE Baltimore. item 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of He 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CUNNINGHAM MEM. PR. Acg5, 2005 ST. ALBANS W. VING. Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 6'ARY L. ROLYNS FON. HONE 21. Signature of Funeral Service License oller FREDERICH MO 21701 110 WEST SOUTH ST X. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause greach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consecuence offi Examine physician and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as the attending IF FEMALE: use If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day 5 ☐ Other (specify) P.O. I detached 9□Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 3□ DOA 2 ER/Outpatient ၉ 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 □ Pending investigation (Month, Day Year) death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifis Name and address of person who completed cause of death (Item 23a) (Type

Registrar

State

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31. Date filed (Month, Day, Year) AUG 1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 2008 5:45 pm^M 11, August Frever /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 11 Freyers Lane Conowingo 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Director Maryland 82 12/18/1925 219-16-9537 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or Items 23a or 28a-f sho event, it a Medical Examination be putified at 1 ☐ Yes 2 No Director Maryland Conowingo Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21918 S. A. Funeral 11 Freyers Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XNo ģ Specify 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 is marked other than "
r traumatic event, II Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rutkowski Wojciehowski Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important; if item 27 is any Injury or other trau Frances Wacker (Daughter) Freyers Lane Conowingo, Maryland 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore City, MD Holy Rosary Cemetery: Simplified of Funeral Service Long 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Ess<u>ex, Mary</u>land 21221 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 X No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 📉 No 1 TYes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of perso

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26244 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kathleen Elizabeth Griggs 08-09-2008 1835 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 💢 F Months Days Min. 218-80-2287 48 10-27-1959 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3708 A Ady Rd 21154 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Asst. Purchasing Agent Plastic Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Sweeney Lelar Gilbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 A Ady Rd Street, MD 21154 James J. Griggs (Husband) 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 08-16-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21015 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe PHEUMONIC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 embolism 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Outpatient 3 DOA Time of 28d. Describe how injury occurred

Physician /Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

death with the Maryland

21215-0036

Baltimore,

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August

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Innortant: if Item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, Ite Medical Exeminer must be notified at once.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Examine Physician/Medical þ Completed Be Medical Certification: To

IF FE	EMALE:
	Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
	9 🗆 Olikilowii

1 ☐ Yes 2 🗹 🕅	lo	Hospita	i: 1 1 inpatient	2 🗆	ER/C
7. Manner of Death 1 Natural 2 Accident	5 Pending investigation		. Date of Injury (Month, Day, Y	ear)	28b.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of contifier	Jehanl
30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)

2008

6 Could not be

determined

063420

DR.

Bel Aue, MD

August 9, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DR. ZUB AUR Khaval 31. Date filed (Month, Day, Year)

14

3 Suicide

4 Homicide

500 upper mesaplake 32. Registrar's Signature

Registrar

	Division of Vital Records, P.O. B
-	To the Hospital or Attending Physician: The law requires that the deat
4	within 24 hours after death.
	To the Funeral Director: After this certificate has been signed by the att
	Completely filled in by the funeral director, page 2 should be detached for

			State of Maryland / Department of Health and N State of Maryland / Department of Health and N Certificate of Death		iene 2000 2024.			
			1. Decedent's Name (First, Middle, Last) Francis A. Grasso	2. Date of Death	3. Time of Death			
	Physicia		Francis Joseph Grasso	AUGUST	10 2008 04:30 AM			
Mark Sales	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death			
and I			Baltimore Washington Medical Center Glen Burnie		Anne Arundel			
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Day, Feb. 28,	Year) 9. Birthplace (State or Foreign Country) NJ			
	ס		Usual Residence of Decedent		10d. Inside City Limits			
	show	<u>_</u>	10a. State 10b. County 10c. City, Town or Location		1 ☐ Yes 2X No			
	he M.	ect	MD Anne Arundel GLen Burnie 10e, Street and Number 10f, Zip Code	11	Og. Citizen of What Country?			
	a or	흐	307 Mary Lou Avenue 21060	,	U.S.A.			
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	ecify Yes or No-	14. Race - American Indian,			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Fra. i incl. further confined at anone.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 X es, Specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	Rican, etc.)	Black, White, etc. Specify: White			
2-0	2 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)		16b. Kind of Business/Industry			
21	thin 7 re. ian "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	_				
	ed wi	So	4 Accountant 17 Father's Name (First, Middle, Last) 18. Mother's Name		Accounting			
and	be fill hall he ed otl	Be	17. Father's Name (First, Middle, Last) Joseph Grasso Josephin					
Ž	hould d Me mark matic	욘	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (<i>Street and Number or Run</i>					
Maryland	nd 2 s Ith ar 27 is 1 trau		Mr. John Grasso / Son 6 Leymar Road Glen Bur					
	s 1 ar f Hea item 3		20a. Method of Disposition 1 X Burial 2 Cremation 3 D Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug		20c. Location - City or Town, State			
E	Page: nent o nt: If		1 ABBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Vets. Cem. 200	Crownsville, MD				
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sin	ngleton 1	Funeral & Cremation			
<u> </u>	P a m a		Mark a farm Mo1357 Services 1 2nd Aver					
L			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est, Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Congostive Heart Failure Due to (of as a consequence of): Coronar Arter, Disease					
2	/Medical Examiner		Due to (of as a consequence of):					
		ē	Sequentially list conditions, if any reading to immediate					
	uted d ansit	Examiner	trans, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
oʻ	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):					
68760,	ate b	dical	d					
	ertific ding p		IF FEMALE:					
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
P.O.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	ıysic	1 Yes 2 No 9 Unknown					
	that ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute to the cause of death?			
rds	quire; an sig uld be			1 □ Y€	es 2 No 3 Probably 4 Unknown			
ဝ	aw requir as been s 2 should	Completed		24a. Was a				
Ä	The late ha			perform	med? death? 2. No 1 ☐ Yes 2 ☐ No			
/ita	cian: ertific octor,	Be (eyaminer?	n (Check only one)				
of \	Physi this c			me 5 Residence 6 Other (Specify)				
Division of Vital Records,	ding I. After funer	tion	27. Manner of Death 128a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 12	28d. Describe no	28d. Describe how injury occurred			
İSİ	Atten deat ctor: by the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, street, factory, office		reet and Number or Rural Route Number,			
<u>5</u>	al or safter	Certification: To	4 ☐ Homicide building, etc. (Specify)	City or Town, State)				
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Check only one)					
	o the vithin o the comple	Mec	29b. Signature and title of certifier 29c. License number		9d. Date signed (Month, Day, Year)			
	->-0		Hen Francis MD. DO27415	F	Lyver 10, 2008			
	4		30. Name and address of person who completed cause of death (Item 23a) (Type. Print)					
	,		& HENRY Francis MD, BAltimire Washinton Mezint	Center	•			
	Sta		31. Date filed (Month, Day, Year) AUG 1 4 2008 32. Faistrar's Signature					
	Registr	ar	HART & CANA TO TO TODAY					

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DHMH 17 Rev 1/2001

OCME 2006

State 31. Date filed (Mo Registrar O.C.M.E

111 Penn Street, Baltimore, MD 21201

August 9, 2008

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

m

Donna M. Vincenti, MD

For State Registrar		State of Ma	ryland /	Departme Certific			and Mei		lene eg. No. 2	2008	26247
1. Decedent's Nam	ne (First, Middle, Last)	TROLD HAN	DUDGE				2.	Date of Dea Month AUG	th		3. Time of Death
/Medical	STANFORD If not institution, give s		IBURGEE		itv. Town. o	r Location o	of Death	AUG	_	008 ounty of Death	11:04 A M
Examine	L NAVAL ME		TER		BETH	ESDA				MONTGO	
Funeral 5. Social Security N	1 🔯	7. Age	73	birthday) If Un Yrs. Mont	der 1 Year hs Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day 1 / 1 0	, Year) 1 0 3 5	9. Birth	nplace (State or Foreign untry) yland
Director 215-30- Usual Residence o	f Decedent							1/10/	1933	Mai	
Tor State MD MD MD MD MD MD MD MD MD MD MD MD MD	Montgom	ery		own or Location Evy Cha	ise						10d. Inside City Limits 1X Yes 2 □ No
th Min the Mark the Mark the Mark the Mark the Mark 10e. Street and Nu 10e. Street and Nu 156 56 30 William 10e. Street and Nu 156 56 30 William 10e.	sconsin .	Avenue #	[‡] 506	10f.	Zip Code 208	15		1	0g. Citize	en of What Coi	untry?
beartimore, Maryland 21215-0036 Demuit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mind or other traumatic event, the Medical Examiner must be notified at one of the Maryland Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed at one of the Maryland of Director. To Be Completed by Funeral Director. To Be Completed at one of the Maryland of Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed by Funeral Director. To Be Completed at one of the Maryland of Director. To Be Completed at one of the Maryl	ried 2X Married	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates:) -	ecedent of H specify Cub s 2XNo	lispanic Oric an, Mexican Specify:	gin? (Specif i, Puerto Ric	y Yes or No- an, etc.)		4. Race - Amer Black, White Specify: W	
Maryland 21215-0036 Maryland 21215-0036 To should be filed within 72 hours aff the and Mental Hygiene. To should be filed within 72 hours aff the and Mental Hygiene. To should be filed within 72 hours aff the medical Examin 1.7 transmatic event, the Medical Examin 1.7 Each Ha To Be Completed by Ha 19a. Informant's N Since Hygiene.	15. Decedent's Edu cify only highest grade ondary (0-12)	cation completed) College (1-4or 5- 5 +		6a. Decedent's U (Give kind of life. DO NO Perio	work done Tuse retired	during most d)	t of working			of Business/I edical	
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reo Ha	mburger							iller		,	
19a. Informant's N	lame/Relationship (Ty		1								ip Cod 20815
Susan H 20a. Method of Dis	amburger	/Wife	20b. Place	5630 We of Disposition (etery, crematory			Ave.			vy Cha	
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Debarting important import	uneral Service Licens	9.,									CE, P.A. ng, Md20910
23a. Part1. Enter shock, or her	the disease, or compli art failure. List only or	cations that caused ne cause on each lin	the death. D	o not enter the r	mode of dyir	ng, such as	cardiac or re	espiratory arr	rest,		Approximate Interval Between
Physician /Medical Immediate Cause disease or condition resulting in death)	on ,			SON'S DI	SEASE						Onset and Death
Examiner		Due to (or as a	a consequen	ce of):							
Sequentially list or if any, leading to in Cause. Enter und.	onditions, mmediate	Due to (or as a	a consequen	ce of):							
figare be executed from the figure of the fi	r injury is Last	Due to (or as a	a consequenc	ce of):							
68760, ificate be except as the burial- edical Ex		l									
A GRING PH Se as the seast		3c. If yes, outcome	of pregnancy							ld Data of dali	
Is FEMALE: 23b. Was deceded in the peath certification of the peath certifi	2 months?	1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal de	ath 3□Ectop	ic pregnanc (specify) _	у			23	3d. Date of deli Month	Day Year
d by Ph	ificant conditions cor	ntributing to death bu	ut not resultin	g in the underlyir	ng cause giv	ven in Part I.		23e. Did to			the cause of death?
The law require page 2 should be completed I								24a. Was a		24b. Were au	topsy findings available
The lar								autop: perfor 1∐ Yes	med? 2 X No	death? 1 ☐ Yes	completion of cause of 2 ☐ No
Section 1	i li	lospital:	0000	10.4-4i-4 2F	Oth	ner:		Check only or			
D 1 Yes 2 1 Y	th	28a. Date of Injur (Month, Day	nt 2 □ ER/ ry 28	b. Time of Injury	28c. Inju	4 🗀 NU		5 ∐ Resid d. Describe h		☐Other (Spec	cify)
trending trendi	5 ☐ Pending investigation 6 ☐ Could not be			M	1 🗆	Yes 2□					
Division or Vital Records, tal or Attending Physician: The law requires t s after death. al Director: After this certificate has been signe ded in by the funeral director, page 2 should be or the completed by Certification: To Be Completed by Certification: To Be Completed by Certification: To Be Completed by Certification: To Be Completed by	determined	28e. Place of inju building, etc		, farm, street, fac	ctory, office		281	. Location (S City or Tow		Number or Ru	ıral Route Number,
									201100(0) -		
29a. Certifier (Check only one)	1 ☑ Certifying Phy 2 ☐ Medical Exami		examination								
29a. Certifier (Check only	2 Medical Exami	ner: On the basis of	examination		tion, in my	opinion, dea	ath occurred	at the time,	date and p	place, and due signed (Monti	h, Day, Year)
	2 Medical Exami	ner: On the basis of and manner sta	examination ated.	and/or investiga	tion, in my	opinion, dea se number 243094	(VA)	at the time, o	29d. Date	signed (Montl	to the cause(s) h, Day, Year)
30. Name and add	2 Medical Exami	ner: On the basis of and manner sta	examination ated.	and/or investiga	tion, in my	opinion, dea se number 243094 NAT	(VA)	at the time, o	29d. Date	signed (Month CG OS ICAL CI	to the cause(s) h, Day, Year)

the Hospital or Attending Physician: To the

OCME 2006

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Donna M. Vincenti, MD

muc 1

31. Date filed (Month, Day, Year)

NL

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 9, 2008

and manner stated

Assistant Medical Examiner

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 37 AM **Physician** John 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakcrest Village Health Center Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear Min. Months Days Hours 1**X** M 2□ F 87 May 15, Director 182-12-0969 1921 Pennsylvania Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d Inside City Limits 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene, filem 27 is marked other than "natural", or items 23a or 28a-f show reither traumatte event, the trained Exerting at 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g Citizen of What Country? 8820 Walther Blvd #3118 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: white Be Completed by 3 X Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) <u>sales manager</u> Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Vincent Hughes Margaret Milligan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Feldhaus/son in law 3901 52nd Sreet NW Washington, DC 20016 permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical as IF FEMALE: yes, outcome of pregnancy
☐Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. Records, Vital 0 of Division

24 hours after deat filled in by Hospital completely within 2 To the

> State Registrar

Medical

29a. Certifier

BANCE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

30 Name and address of person who completed cause of death (Item 33a) (Type, Print)

ÀUG 14

egistrar's Signature

ORIGINAL

ily

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1:06PM **Physician** Howe AUGUST 2008 Michael 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 9,1953 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Maryland 55 217-66-3152 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a State 28a-f show 1 Yes 2 No ntal Hygiene. ed other than "natural", or Items 23a or 28a-f s event, the Medical Examiner must be notified Directo Carroll Manchester Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21102 USA. 3450 Augusta Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer - Lieutenant Police Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Howe marked Irene Mavromihalis Η. Lyman ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any injury or other trau 3450 Augusta Road Manchester, Maryland 21102 Debra L. Howe / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Cemetery 8/16/08 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Fulleral Service Live see 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc.Towson,Md.21204 are 23a. Part 1. Enter the disease, o complication shock, or heart failure. List only one Approximate Interval Between Onset and Death of s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final day **Physician** Intracerebral disease or condition resulting in death) Hemorrhage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 ☐ No 3 ☐ Probably 4 Munknown 1 TYes Hypertension Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 1 ☐ Yes 2 ☐ No 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ this (nours after death.

neral Director: After this of filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation or Attending Injury 1 X Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of Ç August 11,2008 D0066613 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JOSEPH D. JORDAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

		For State Registrar		f Marylan	d / Depa		of He	ealth a		-		20	n s	26251
		Decedent's Name (First, Middle	Last)							2. Date of De				3. Time of Death
Physicia		Margaret H	elen Indi	lisano						Month Augus	t 12		Year 08	12:20 A ^M
/Medic Examin		4a. Facility Name (If not institution	give street and nu	mber)		4b. City,	own, or L	Location c	of Death		4c.	County o	of Death	
	•	1133 Wedgewood	d Road				Bal:	timor	ce					
Funeral		,	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs.		If Under Months	Year Days	If Under:	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year)</i>		9. Birthpl Count	ace (State or Foreign try)
Director		215-01-3330	ILIM ZKAF	89	Yrs.					Feb. 2	25, 1	919	Mary	/land
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the 1	rec	MD 10e. Street and Number		рат	LIMOTE	10f. Zip	Code				10g. Citi	zen of W	hat Count	ry?
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death	Completed by Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-		- America	
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ours	d b	3 Widowed 4 Divorced	Year or D	Pates:										
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within ene. than	п	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us Homem						Own :	Uomo	
filed v Hygid ther	ပ္	17. Father's Name (First, Middle, I	ast)			Homem		18. Mothe	er's Name	e (First, Middle				
d be ental ced o	o Be	William M. Mcl						Δnr	na Pi	ruchnes	le i			
shoul nd Ma marl	2	19a. Informant's Name/Relationsh			19b. Mailii	ng Address	(Street a			al Route Num		r Town,	State, Zip	Code)
nd 2: alth a 27 is		Mario Indilisa	no Husb	and	1133	Wedge	boow	Road	i; Ba	altimor	e, M	D 21	229	
s 1 a of Hea item		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crea	osition (Nam	e of her place	,)	[Date	20c. Lo	cation - (City or To	wn, State
Page nent d int: If		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S _t			lantic	Crem	ator	y 8			G1en			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinational Legislation once.		21. Signature of Funeral Service	ieensee	V	2:	2. Name an	d Address	s of Facilit	ySte:	rling A	ishto	n Sc	hwab	Witzke
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		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat		A	-				arrest,			Approximate Interval Between
Physician	<u>.</u>	Immediate Cause (Final disease or condition	a	Ad	ranc	ed	Dev	nen	Tic					Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conseq										
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ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	dence oi).									
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):									
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h cer endin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnation		⊒Ectopic p	oananau					23d. Date	e of d elive	*
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has b	Completed	COFF	<u> </u>							24a. Wa aut	opsy	p	rior to cor	psy findings available npletion of cause of
: The cate , pag	S									1 □Yes	formed? 2 Devo		leath?	2 □No
ician certifi ector	æ	25. Was case referred to medical examiner?	Hospital:				Othe	r·		h (Check only				
Phys r this ral dii	.To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatie		Bc. Injury	4 🗆 N		28d. Describe				y)
ding h. Afte fune	tion	1-Natural 5 Pending 2 Accident investig) (Moi	nth, Day, Year)	Injury	м	Work'	?		Edg. Dodding	711017 111701	,		
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al or after	erti	4 ☐ Homicide determ	City or Town, State)											
ospita hours inera ly fille		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kno	owledge, deat	th occurred	at the tim	ne, date a	nd place,	and due to th	e cause(s	and ma	inner as s	tated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only •2 Medical one)	Examiner: On the and mar	basis of examination	auon and/or ir				ain occur	rea at the time	e, uate an	u piace, a	and due to	(iie cause(s)
To tl withi To tl	Ž	29b. Signature and title of certifier		Di	A	290	License	number			29d. Da	te signed	i (Month,	Day, Year)
		1 Kterna	ndex	ritten	ding		万 2	>0]	33		X	113	100	3
1		30. Name and address of person	who completed cau	ise of death (Iter	n 23a) (Type,	Print)	0 1	1.		0	مدى	7 -		1:220
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Sta Registr		31. Date filed (Month, Day, Year)	18	Registrar's Signa	Sheet	1		•						
- Incgisti	an .	AUG 1 4 20	UU JURIES	W /V	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26252 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea Month **Physician** Jackson AUGUS, 2008 01=45 AM Jean /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Sind Hospital of Balkmere If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 8. Date of Birth (Month, Day 03 23 5. Social Security Number 7. Age (In yrs. last birthday) 8. **Funeral** Year) Days Hours 62 Director 248-78-6964 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rutiflied at once. 1 X Yes 2 □ No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 U.S.A. 2704 Steele Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) Post Office Letter Carrier 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Alberta Jackson Udell Vernon ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 2704 Steele Road, Baltimore, Md 21209 Elicia J. Jackson-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 8/18/08 Owings Mills, Md 4 □ Donation 5 □ Other (Specify) 21. Signatur 22. Name and Address of Facility March F/H West of Funeral Service Licensee 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart believe. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute blood loss anemia **Physician** 2 days /Medical Due to (or as a consequence of) **Examiner** Acute renal tay lure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin Revactory sephe show sician and burial-trans P.O. Box 68760. attending physician for use as the burial Physician/Medical Respiratory failure 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ₺ No 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Divilated Cordianyapathy 2 No 3 Probably 4 Unknown 1 Tes Completed peen Chronic Amal Eballation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 DNo 2 5 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RESO00

State Registrar

DHMH 17 Rev 1/2001

Sinai Hospital of Baltimere

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Jonathan Henesch

AUG 1 4 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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al Certif	29a. Certifier 1 X Certifying	building, e	etc. (Specify)	edge, death	occurred at	the time	date and place	City or To	wn, State	and manner as s	stated
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by			but not resulti	ng in the un	derlying car	use given	in Part I.				
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2	_			19b. Mailin	g Address (Street an	d Number or R	ural Route Numi	ber, City o	or Town, State, Zi	p Code)
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Direct	10e. Street and Number			DCTTT	_		1011		10g. Ci		
or	10a. State 10b. County MD Worces	ster									10d. Inside City L
	167-18-3927 Usual Residence of Decedent	1 ∑ M 2□ F	88	Yrs.	Months	Days	Hours Mir	July 1	l4, 1	920 Penr	place (State or Fo intry) nsylvania
			Age (In yrs. las	st birthday)	If Under			8. Date of B	irth	Worceste	
cal		give street and number	r)		4b. City, T	own, or L	ocation of Dea				9:25
ian		,						2. Date of D Month	Da	y Year	3. Time of De
	edical Certification: To Be Completed by Physician/Medical Examiner	John Jerdon 4a. Facility Name (If not institution, Berlin Nursin, S. Social Security Number 167–18–3927 Usual Residence of Decedent 10a. State 10b. County MD Worces 10e. Street and Number 7 Wood Duck Drill Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L. John W. Jerdon 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Burial 2 Cremation 4 X Donation 5 County Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Burial 2 Cremation 4 X Donation 5 County Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon/so 20a. Method of Disposition 1 Second 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informant's Name/Relationsh John Jerdon 19a. Informan	JOHN Jerdon 4a. Facility Name (If not institution, give street and number Berlin Nursing & Rehab 5. Social Security Number 6. Sex 167-18-3927 1X M 2 F 10a. State 10b. County MD Worcester 10a. State 10b. County MD Worcester 10a. State 10b. County MD Worcester 10a. State 10b. County MD Worcester 10a. State 10b. County MD Worcester 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Wes, Give 2 Wes, Close 2 Wes, Close 3 Widowed 4 Divorced 1 Wes, Close 1 Wes, Close 2 Wes, Close 3 Widowed 4 Divorced 1 Wes, Close 2 Wes, Close 3 Widowed 5 Wes, Close 2 Wes, Close 3 Widowed 5 Wes, Close 3 Widowed 5 Wes, Close 3 Widowed 5 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 6 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Wes, Close 3 Widowed 7 Widowed	Social Security Number Social Security Num	As Facility Name (If not institution, give street and number)	Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 167-188 Social Security Number 168 Social Secur	Social Security Number 16. Sex 167-18-3927 17. Age (In yrs. last birthosy) 17. Textures 16. Sex 167-18-3927 17. Age (In yrs. last birthosy) 17. Textures 16. Sex 16.	JOHN Jerdon Sr 10. Street and Number 10. Sex No Specify County No No No No No No No No No No No No No	Social Security Number Security Securi	John Jerdon July 31, 4s. Sally some and number) 4s. Cally Town, or Location of Dash Berlin Nursing & Rehab Service and number) 4s. Cally Town, or Location of Dash Service and Number 16s. Sale 16s. Call	John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon John Jerdon Jernon Jerno State John Jerdon John Jerdon Jernon Jerno State Jernon Jerno State John Jerdon Jerno Jerno Jerno State Jerno Jerno Jerno State Jerno Jerno Jerno State Jerno Jerno Jerno State Jerno Jerno Jerno State Jerno Jerno State Jerno Jerno Jerno State Jerno Jerno Jerno State Jerno J

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	Physici /Medic		Cla	rence Wale	iro	James		July	27 2008	9:28 P ^M
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	Funeral		5. Social Security Number 6. S	Sex. 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	v Yearl . C	thplace (State or Foreign ountry)
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336	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates;		1□Yes 2□No	Specify:		Specify: Bi	. ACK
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	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: Completely filled in by the funeral director; completely filled in by the funeral director;	Medical	one)	and manner stated.					·	
	Vitl Con	2	29b. Signature and title of certifier	16.	P .	29c. Licens	e number		29d. Date signed (Mor	nin, Day, Year)
	-1			tauzi.	KIZVI	MIMMO	62180	<u> </u>	July 2	8,2008
	1		30. Name and address of person who					. 90 1	, 0	
	1	6		2 VC 400 WL	st Jo	reth o	1. Fred	super	x. 2170	1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	el a				
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JNK UNK		State of Maryland / Department of Hea		lygiene	200	0 2025
Physicia	_	Decedent's Name (First, Middle,Last) Audrey Lee Jurewicz	X(()	2. Date of Death		3. Time of Death
Medical Exami		AUDREY LEE JUREWICS		July 28, 20		1100 hrs
r7.		610 Marvel Road Sali	y, Town, or Location of Death isbury		4c. County of Death Wicomico	
Funeral Director		157-72-3046 1_M 2XF 26 Yrs. Mor	nder 1 Year If Under 24Hrs hths Days Hours Min	_	(MM/DD/YYYY) g. Birt D / 1981 Foreig Co.	
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			**************************************	10d. Inside City Limits
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th the Maryland 13a or 28a-f sho notified at once.	I Director	611 EAST RAILROAD AVE. 2	Zip Code 1804		g. Citizen of What Cour	itry?
15-0036 filed within 72 hours after death with the Maryland Hygiene. 24 other than "natural", or items 23a or 28a-f she 1, the Medical Examiner, must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 No	edent of Hispanic Origin? (Secify Cuban, Mexican, Puerto 2 No specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ White, etc.	
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36 nin 72 h E. than "n dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2YRS BAKERY I	vorking life. DO NOT use ret	urea)	WALMART	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	GARRY JUREWICZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	LINDA ess (Street and Number or	OLCSVA		7:- 0-4-)
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s l an f Hea If iter er tra		20a. Method of Disposition 20b. Place of Disposition (Notermation 2 Cremation 3 Removal from State Crematory or other plants)	ce)	Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specify: MTRO CREMA 21. Signature of Funeral Service Licensee 22. Name a	ATORY 08 nd Address of Facility	/07/20	08 BALTO.	COUNTY,MI
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Division To the Hospital or Attendit within 24 hours after death. To the Faneral Director , completely filled in by the fi	edica	29a. Certifier ((Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred		nd place, and due to the	e cause(s)
	2	1 40 11 11	9c. License number O.C.M.E.		29d. Date signed (Mor July 29, 2008	nth, Day, Year)
15	-	Tamput buthall, MD 30. Name and address of person who completed cause of death (Item 23a)				
			nn Street, Baltimore, I	MD 21201	·	
Sta Regist	ite rar	31. Date filed (Month, Day Year) 2008 32 Registrar's Signature)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician EMMA** E. JEFFERSON AUG. 9,2008 10PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1218 RAMBLEWOOD ROAD BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F Yrs. 214 26 7120 MAR.2,1931 MD. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Examiner must be notifled at BALTIMORE 1√Yes 2 No Director N/A MD 1218 RAMBLEWOOD RD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 1218 RAMBLEWOOD RD. 21239 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines and. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AIDE ST. JOSEPH HOSP.

18. Mother's Name (First, Middle, Maiden Surname) 2 YEARS NURSE"S AIDE 17. Father's Name (First, Middle, Last) Be MARGARET A. HILL JAMES H. STEWART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CARLITA R. COLVIN (daughter) 1218 RAMBLEWOOD RD. BALTO, MD. 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MARYLAND Natl.Cem. Aug.18,2008 Laurel,Md. 4 Donation 5 DOther (Specify) St nature of Funeral Service Licensee B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, MD. 21213 1412 E. 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute eukemia month myeloid resulting in death) Due to (or as a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2.**2**No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No 2 No director, Be

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

within 24 hours af

To the Funeral D

completely filled in

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filled in by the hours after deat

31. Date filed (Month, Day, Year)

SMOKET

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200M 609

AUG 1 4 2008

M, MD

PHYSICIAN

Registrar

29c. License number

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BALTIMORE

BROADWAY

29d. Date signed (Month, Day, Year)

11,2008

21205

			For State Registrar	State of Marylar	-	artment of H <i>rtificate of L</i>				008	2625
		9	Registrar 1. Decedent's Name (First, Middle, Laster)	st)	Ce	Tillicate of L	Jeaui	2. Date of De		000	3. Time of Death
	Physici		GLENN IRA		10			Month AUGUS	Day	9008	730 AM
7	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea			nty of Death	
#	s has me a grain in the second		3114 GRACEA			SILVE				Thom	
	Funeral		5. Social Security Number 6. S	ex 2□ F 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	y, Year)	Count	
	Director		Usual Residence of Decedent		ł .			APRILS	.1919	PENS	SYLVANIA
	ylanc how at		10a. State 10b. County		ty, Town or Lo					10	od. Inside City Limits
	e Ma Ba-fs	Director	MD MONTHO	MERY S	ILVE	S Sprin	567	1			1 MYes 2 No
	with th	Dire	10e. Street and Number	24.0		10f. Zip Code) = 11		10g. Citizen o		ry?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	3114 GRACE F	12. Was Decedent Ever in U	.s. 13.	Was Decedent of Hi		Specify Yes or No	- 14. R	ace - America	an Indian,
2	or iten		1 Never Married 2 Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		erto Rican, etc.)		lack, White, e	etc.
3	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Li Yes 2 Le No	Specify:		Spec	cify: WH	ITE
י ל	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of w	orking	16b. Kind of	Business/Ind	ustry
7	within ene. than he Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	 	751-C15	•		Enu	CATIE):-)
7	filed Hygi other ent, tl	Be Cc	17. Father's Name (First, Middle, Last)		1 11	131213		ame (First, Middle			
0	should be and Mental marked c	To B	EMMETT KI	RKLAND			ELIT	CABETH	POLL	DCV	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a	and Number or I	Rural Route Numb	er, City or Tou	vn, State, Zip	Code)
2,2	1 and 2 Health em 27	1 8	BARBARA KIRKLAM		3114	GRACEFIEL	40A CL		८ रहे		D 7040
5	Pages 1 nent of H nt: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other plac	i i	Date		n - City or Tov	
	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify 21. Signature of Funeral Serifice Licer	() CMS	D THIODIE	2. Name and Address	TRY AVW	15TH, 2006	HANON	urb w	Δ
מ	permi Depa impo any l		21. Signature of Puneral Service Licer	see				رجا	e	, MICD	MD 21076
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the deat	th. Do not en	ter the mode of dyin	g, such as cardi	ac or respiratory a	rrest,		Approximate
	Physician		Immediate Cause (Final			GE RE				1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consec		GE PCE	NAL.	V 130193			4154140
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	ificate g phys	edical		• U							
5	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnancy			23d. I	Date of delive	ry
ב ב	deat be atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)				Month	Day Year
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	he lav e has ge 2 s	ldm						24a. Was auto perfo		prior to con death?	psy findings available npletion of cause of
5	an: Tificate		25. Was case referred to medical				26 Place of D	eath (Check only o	2□No	1 ☐ Yes	210 No
>	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3 DOA Othe		, ,	dence 6 □0	Other (Specify	·)
5	ng Ph Iter th		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury		28d. Describe			<u></u>
2	tendir eath. or: Al	atic	2 Accident investigation			M 1□	Yes 2 □ No				
	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, st fy)	reet, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rural	I Route Number,
3	pital ours a eral [29a. Certifier 1. Certifying Ph	ysician: To the best of my kno	wledge deal	h occurred at the tin	ne date and nia	ice, and due to the	cause(s) and	manner as st	ated
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours afterdeath. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death oc	curred at the time,	, date and plac	ce, and due to	the cause(s)
	To the within To the complete	Me	29b. Signature and title of certified	1 -1 1		29c. License	e number		29d. Date sig	ned (Month, L	Day, Year)
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	1		30. Name and address of person who	. A	/				7		
	3.		31. Date filed (Month, Day, Year)	32. Registrar's Signa		CLEIFUS T	20AD 5	ILVIN S!	BINK	E SW	9904
	Sta	100	or Date filed (Moriti), Day, real)	Joe. FAMUISITAL S SIGNA	aule						

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State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department State of Maryland / Department / De	artment of He 14/08(hb rtificate of D	ealth and l eath	Mental Hygi	ene g. No. 2008	26258
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Richard Kelleher			2. Date of Death Month July 30	Day Year	3. Time of Death 3:15 PM
- Barage	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventis Hospital	4b. City, Town, or L Takoma)	4c. County of Death	
	Funeral Director		5. Social Security Number 018—22—2857		Hours Min.	8. Date of Birth (Month, Day, 4/13/19	Year) 9. Birth	pplace (State or Foreign intry) MA
	aryland show	×	Usual Residence of Decedent 10a. State	cation ege Park				10d. Inside City Limits 1 XYes 2 □ No
	vith the Mi	Director	10e. Street and Number 9150 Baltimore Avenue	10f. Zip Code 2074	4O	10	g. Citizen of What Cou USA	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinating must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical"	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupati kind of work done du DO NOT use retired) nqineer			6b. Kind of Business/li Space Ager	,
land 2	S = 2 5	To Be Co	17. Father's Name (First, Middle, Last) James Kelleher		8. Mother's Nan Blanc	ne (First, Middle, M he Toole	laiden Surname)	
	es 1 and 2 should b of Health and Ment f Item 27 Is marked ir other traumatic e	-		ng Address (Street an Azel Road,			City or Town, State, Z. 2184	ip Code)
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 iry or other tr.			sition (Name of matory or other place) 's Cemeter		Date 2 04/2008	Randolph,1	
Balti	permit. Pages Department of Important: If I any Injury or once.		DOLOGG PROGRAM	2. Name and Address Charles L.	Steven	s Funeral	l Home Inc. Ltimore, M	21 230
	Physician /Medical Examiner	e 15	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ter the mode of dying,	such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Sepsis	zan De	plun	Tim 5	syndrom	Į.
O. Box 6	ath certifi attending or use as	Physician/Med		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	luires that the de n signed by the a ld be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to s 2 ☐ No 3 ☐ Pro	
al Records,	The law ate has t page 2 s	Completed				24a. Was an autopsy perform 1 🗆 Yes 2	prior to c death?	topsy findings available ompletion of cause of
or Vital	Physician; The rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Other:	4 ☐ Nursing H		nce 6 ☐ Other (Spec	eity)
DIVISION (To the Hospital or Attending Phys within 24 hours after of eath. To the Funeral Director: After this completely filled in by the funeral directorial.	Certification: To	27. Manner of Death Natural 5	Work? M 1 □ Ye	at es 2 □ No	28d. Describe how 28f. Location (Str. City or Town,	eet and Number or Ru	ral Route Number,
2	Hospital of thours af uneral Dely filled in	ledical Cer	29a. Certifler (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time	e, date and place	e, and due to the ca	ause(s) and manner as	stated. to the cause(s)
	To the h within 24 To the F complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License r	number D645	61 29	9d. Date signed (Month	i, Day, Year)
	(H)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	7.1	101	+13110	700:3
	Sta	te	VWW HWW 7600 CWV 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature	II HVL.) (ako	ma I'm	K, MV.	10916
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Amend 4a, perMD G882 8/14/08 TT

State of Maryland / Department of Health and Mental Hygiene 2 1 8

1- State Amend 19b per FH G882 8/19/08 Entificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Car1 \mathbf{F}_{\bullet} Linton Jr. August 8, 11:55P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 217 Maple Street Avenue Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 212-80-4717 ty⊡M 2□F 48 Months Days Hours Min. Director MD 11/20/1959 Usual Residence of Decedent 10a. State 10c. City. Town or Location items 23a or 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at MD Director N/A Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Maple Avenue Funeral 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married P 1 □Yes 2 No Specify: white þ Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 Is marked other than any injury or other traumatic event, the Mance. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Carl F. Linton, Sr. ပ Corinne L. Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann T. Linton / Wife 217 Maple Avenue, BAltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cem. 8/13/2008 Baltimore Maryland 4☐Donation 5 ☐Other (Specify) neral Service Licensee 22. Name and Address of Facility Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Mouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been si 1 ☐ Yes 2 ☐ Yo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 □Yes 2√2No s after death.

I Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Physician: Hospital or Attending To the Hospital of within 24 hours a To the Funeral E

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

1600 atems St. Butter MD MO 31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

ORIGINAL

0002388

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 26260 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DUBREVIL Physician MILDRED Month Year 5:05 PM /Medical 08 09 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Little Sisters of the Poor Catonsville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 219-01-9215 Months Days Hours Min. Yrs. Director 95 10/16/1912 Maryland Usual Residence of Decedent 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Director 1 ☐Yes 2 ☐No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or iury or other traumatic event, the Medical Exambles must be not 601 Maiden Choice Lane Funeral 21228 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2 🛛 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Printing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles duBreuil Mildred Richardson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Peach Ehrmann / Niece Elmhurst Road, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 08/14/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMDNIA disease or condition resulting in death) 1 Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any least your cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit ementia Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to ☐Yes 2 No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 2 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMB ANDAM BASKALAN 3455 WILL 3455 Wilkens Ave. Baltimore MD 21229 327 Registrar's Signature

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	Sex 7. Ag	e (In yrs. last birt	Yrs. Mon	nder 1 Year ths Days	Hours	Min.	8. Date of Bir (Month, Da 7/18	ay, Year)		Birthplace (State or Foreign Country) M:(,
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liberty	-		,	2113						
	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D	ecedent of F	lispanic Orig	in? (Spec	cify Yes or No Rican, etc.))- 1	14. Race - An Black, Wh	merican Indian,
2 Married	1 ☐ Yes 2 🗹 1		11 100,	specify Cab	an, wexican	ruenor	iicari, etc.)		Black, WI	nite, etc.
Divorced	If Yes, Give Year or Dates:		1 ☐ Ye	es 2 M/No	Specify:				Specify:	White
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medical					26. Place	of Death	(Check only o	ne)		
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Could not be	e 28e. Place of inju	Inc. At home for	m street for	stoni office			06	04		D 10 1 11 1
determined	building, etc		iii, street, rat	ciory, office		28	City or Tov	vn, State)	Number or I	Rural Route Number,
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Medical Exar	miлer: On the basis of	examination and	dor investiga	tion, in my o	pinion, deat	h occurre	d at the time.	date and	place, and d	ue to the cause(s)
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State

4 Homicide

29b. Signatupe and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed car

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Alice 715 PM Mary McGarry 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/28/1972 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🖫 F Brooklyn, N.Y 069-50-9477 Director 36 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemplest must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WVBerkeley Martinsburg Director 1 X Yes 2 □ No 10e. Street and Number 122 Tather Drive 10f. Zip Code 25405 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ş 1 ☐ Yes 2X No Specify White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Smuggling Officer Dept.of Agriculture 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis McGarry Alice Mary Sapanski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Mary McGarry/Mother 2983 Avenue S, Brooklyn, New York 11229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Kemoval from State St.John's Cem. 8/11/2008 4 Donation 5 Dother (Special Middle Village, N.Y. 21. Signatur of Funeral Service Vc FHYTTP CRIMINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 MAG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mekstetic Brecst resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be execulted physician and s the burial-trans Records, P.O. Box 68760, 🤇 Due to (or as a consequence of) Physician/Medical attending p as IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 Yes 2 No funeral director, page certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Milrael Miloun 41667 :7.08

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylar	nd / D	epartment of F <i>Certificate of I</i>	lealth and N <i>Death</i>		giene 200 Reg. No.	8 25263
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/Medic Examin		4a. Facility Name (If not institution, given Southern Mary	· ·	al	4b. City, Town, or Clin	r Location of Death		4c. County of De	
Funeral		Social Security Number 6. 8	•	last birth		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2/22/		Birthplace (State or Foreign Country) N • C •
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>		19a. Informant's Name/Relationship (Eric McGeachy/			Mailing Address (Street a 0701 Bail				
DaltIMOTe, I permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Ro		Disposition (Name of crematory or other place ish Cem.	8/18,) 2008	20c. Location - City of Fayette	or Town, State ville, N.C.
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Physician	6 6	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the deat one cause on each line.	h. Do no	ot enter the mode of dyin				Approximate Interval Between Onset and Death
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To the within 2 To the complet	Me	29b. Signature and title of certifier	24 4 4 2 4 2 4 2 4		29c. License	/		29d. Date signed (Mo.	
,0	-	30. Name and address of person who	completed cause of death (Iten	n 23a) (T	ype, Print)	5206		Hugust	11, 2008 ASHiym, MD
Stat	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signa			In Kond	, July t	to Fat w	ASHLEY M. MD.
Registra		AUG 1 4 2008	Block &	dos	all s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year -adden 3:38A M olores tuaust 13,2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ommun 1 If Under 24 Hrs. (In vis. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□ M 2 3 Months Days Hours Min 1790-34-502 Yrs. Director beorgia Usual Residence of Decedent the Maryland 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventural be notified at once. Director 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20740 mo Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No 2 Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 □Other (Specify) 2008 22. Name and Address of 21. Signature of Funeral Service Licensee Funeral, 23a. Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Division of Vital Records, P.O. Box 68760, attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag 1 □Yes 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Elippatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title

State

0

31. Date filed (Month, Day, Year)

Dabak

ALIG 1 4 2008

KUZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

Riverdale, MD 20737

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per dyr 282 3-14-08 yr State of Maryland 7 Department of Health and Mental Hygiene 2 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** August 10 2008 1:30Derielle Milagros Mackey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Ctr Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 ■ F Yrs Aug 9, Director 2008 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified at Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 5426 masefield Rd. Funeral 21229 items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 9 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify \$ Specify: 3 ☐ Widowed 4 ☐ Divorced natural" Black Unknown Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant 18. Mother's Name (First, Middle, Maiden Surname) is marked other 17. Father's Name (First, Middle, Last) Be P Derrick F Mackey Smith Arnetta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore Medical Ctr 27 6701 N. Charles Street Baltimore, MD or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Page:
Department o
Important: If I
any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PREMATURITY disease or condition resulting in death) EXTREME /Medical Due to (or as a consequence of): Examiner TREMATURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed TERM the burial-tran PTURE OF ANNIBLE Due to (or as a consequence of) MEMBRANES attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 1 Natural To the nosperation within 24 hours after death.

To the Funeral Director: After the function of the function o 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of pers empleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

TOUSEN HO

MI)

132. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 18:36 Rosemarie McCloskey August 200ð /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital 900 S. Caton Ave Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 24, 19 Birthplace (State or Foreign Country) Days Hours Months 1 □ M 21X F 78 1930 Pennsylvania 159-28-9501 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Director Maryland Baltimore Catonsville 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 USA 2200 Old Frederick Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 13 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl J. Seydel Anastasia Farrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. McCloskev Husband 2200 Old Frederick Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral Gardens 8/16/2008 Elkridge, MD 21. Signature of Funeral Service Licensee

Mo/490

22. Name and Address of FacilitySterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228

Approximate
Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Acute Arrest days resulting in death) Due to (or as a consequence of) Anoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Stehosi mucus plugging racheal Due to (or as a consequence of): Obstructive Sleep Physician/Medical Apnea IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 KNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed Hypertension h/0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy h/0 Diabetes Mellitus 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Examiner P.O. Box 68760, Rosemarie Récords, Vita ō Division

burial-transi Physician: The law requires that the death certificate be execute the as use for director, page 2 should has or Attending in by Hospital fille

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

nd 2 should be filed within 7 ath and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med

Pages 1 and 2 sl ment of Health an ant; If item 27 is 1

Important; If it any injury or o

Physician

/Medical

within 24 hours after deat To the Funeral Director:

9 State Registrar 29b. Signature and title of certifier ming the Wang, MD

P20659

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St Agnes Hospital 900 S. Caton Ave Baltimore

32. Registrar's Signature

31. Date filed (Month, Day, Year)
AUG 1 4 2008

Amedn 29a, perDVR G882 8/15/08 TT Amend Item 2 per dr., g882,08/20/08dhb

Amend Item 25 per dr., g882,08/14/08dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07/14/2008 3. Time of Death Month Roland B. Mason 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6231 Laurelton Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 28, 19 Birthplace (State or Foreign Country) Hours Months 1**∑**M 2□ F 87 216-12-6105 1920 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD ty∏Yes 2 ☐ No Baltimore Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6231 Laurelton Avenue 21214 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Md school for Elementary/Secondary (0-12) 12 College (1-4or 5+) the blind electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roland Byrd Mason Sr Hilda Viola Lemmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bena Mason/spouse 6231 Laurelton Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 21. Signature of Euneral Service ROITa LO 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 2222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to heart failure. List only one cause on each line. 23a. Part1. shock Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHERO SCLERUTIC HEART DISEASE Due to (or as a consequence of): 1+4PEIZTEN SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 1+ YPERLIPIDEMIN resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 21+1-1 MURS DISUBSU 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ANEUKYSM OF ALDUMINAL autopsy performed? 1 ☐ Yes 2 💢 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation М 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide

Physician: The law requires that the death certificate be executed use as the burial-transit signed by the ettending physicien and d be detached for use as the burial-trar Box 68760 Division of Vital Records, P.O. page 2 should t this certificete s efter deau...
rai Director: After this co...
- In by the funeral director, pe or Attending filled in by within 24 hours e

Physician

Funeral

Director

7 is marked other than "natural", or iteme 23a or 28a-f ehow treumatic event, the Maxilcal Exandriar must be notified at

10

d 2 should be filed within I thand Mental Hygiene.
I is marked other than "r

Pages 1 and 2 s ment of Health ar item 27 is other tre

= 5 permit. Page Department i important: if any injury or once.

Physician

/Medical

Examiner

filed within

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certification;

4 | Homicide

(Check only one)

29a. Certifier

State Registrar 31. Date filed (Month, Day, Year) 1 4 2008

SINDHUJ AMES Registrar's Signature

amu

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mo

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10051191

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 7/17/2008

MIJ 21093

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month James Patrick O'Conor Jr. 6:15 Рм August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F 220-54-9580 Maryland Director November 6,1950 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 XNo Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12704 Ponderosa lane 21057 United States Funeral Hygiene. other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 MXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No ģ Specify. Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) legal permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier Important: If them 27 is marked other the any injury or other traumatic event, Importe. attorney Is marked other 17, Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Patrick O'Conor Sr. Katherine Ellis ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. O'Conor Sr./father 2 Fieldspring Ct. Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Church Cem. Aug. 13,2008 Cockeysville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. O. Mitchell 6500 York Rd. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2008

AUGUST

JAMES O'CONOR

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 14 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 26269 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Peter S. Oliveri 8-8-2008 /Medical 2:23p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Balto. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months Hours **Director** 100-44-9091 56 9-1-1951 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be northed at 10c. City, Town or Location 10d. Inside City Limits Md. Harford Director Fallston 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2508 Roy Terrace Funeral 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after Hygiene. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No ð White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) I Health and Mental Hygier frem 27 is marked other th 12 Stage hand Entertainment 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ould be f Peter Oliveri permit. Pages 1 and 2 should I Department of Health and Men Injury or other traumatic 2 Filippa Pisano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Oliveri Important: If Item 27 any injury or other tra 2508 Roy Terrace Fallston.Md 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-13-2008 Fallston 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Bun a Ille 610 W. MacPhail Rd. BelAir, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated sease) Due to (or as a consequence of) requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ed by the 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate of Vital 1 □Yes 1 ☐ Yes 2 ☐ No 2 🔀 No Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 X Natural 2 Accident 1 □Yes 2 □No after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) the within To the 29b. Signature ad title of certifier Date signed (Month, Day, Year) Me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **ERNESTINE WRIGHT** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) AUG 1 4 Registrar's Signature State Registrar

AUGUST

OLIVER

PETER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death

OPPENHEIMER

ÄÜĞUST

2008

7:15A

Physician /Medical Examiner

1 - For State Registrar

JUDITH

LINDA

Funeral Director

72 hours after

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaniment runt be mailfied at permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, In

Baltimore, Maryland 21215-0036

Physician / /Medical Examiner

signed by the attending physician and be detached for use as the burial-trai peen has certificate

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Hospital or Attending Physician: To the Hospins.
within 24 hours after deam.
To the Funeral Director: After this c this

Division

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL DOVE HOUSE WESTMINSTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/8/1947 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours Min 217-48-6938 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County CARROLL Director MD FINKSBURG 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1711 ANTLER LANE 21048 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Bace - American Indian 11. Marital Status 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Specify: ğ 3X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER BOOKKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **AARON** SCHEPP KATE SCHEPP 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAYE STEC / DAUGHTER 900 WESTMINSTER AVE. HANOVER, PA 17331 20b. Place of Disposition (Name of ANSHE FMUNAH CONG. 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8/13/2008 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Total 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 **X** No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P HOSPICE 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Latural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Eater Street Wistnister MDOINT

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 28b per me.g8822ti084164008cHatth Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ronald Anthony Peters Sr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Hosoi Cheverly corges rince 6-evers If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F Days Hours 578-54-1713 Yrs Director 70 2/8/1938 D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other than "natural" and use be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sl MD Prince George's Bladensburg Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5507 Decatur St. 20710 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 🎇 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Car Sales Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKN ၉ Dorothy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms Linda Peters/daughter 7527 Rock Creek Way, Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 8/6/2008 Catonsville MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Furnital Service to chise 22. Name and Address of Facility Kirkley Ruddick Funeral Home M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Motor Vehicle Accident with /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and stranger the burial-tranger Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE nse 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery for 1 in the past 12 months? 3 ☐ Ectopic pregnancy signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) Month Day Year 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) August 2, 208 28d. Describe how injury occurred Driver of Car Struck Telephone pole 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1047 a M 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide

that the death certificate be executed Division or Vital Records, P.O. Box 68760, After this or Attending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death.

Baltimore, Maryland 21215-0036

29a. Certifier (Check only

4 Homicide

lace of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Flural Route Number, City of Town, State) Aug.

Black 15 burg R

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State

Medical

31. Date filed (Month, Day, Year)

AUG 14

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Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

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State Registrar

AUG 1 4 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 26273 Reg. No. 2 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Day 12:00 AM 2008 ·m. 08 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Ollen Burnie Baltmore Washington If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number Year Months Days Hours 20, 61 1946 MD 212-48-2472 Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 120 Margate Drive 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Phillips Jr. Pearl A. Rich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Janie J. Phillips / Wife 120 Margate Drive Glen Burnie, MD 21060 20c. Location - City or Town, State Aug^{Date}17, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 Glen Burnie, MD Atlanic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Lice Mo/357 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or sear failure. List only one cause on each line.

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

2

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

is marked other than

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

g physician and stransit use as attending p signed by the a been certificate has page 2

law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

ospital or Attending Physicien: Ti hours after death. uneral Director: After this certificate y filled in by the funeral director, pa

Physician/Medical Exam Completed by å Medical Certification-To

within 24 hours a

To the Funeral completely filled

State Registrar

	Immediate Cause (Final disease or condition	Atheruscle	who Co	rdiovas cidas	Distase		sudden	
	resulting in death)	Due to (or as a consequ	ience of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a consequ	ience off)					_
	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1	I death 3 🗆 Ector	oic pregnancy (specify)		23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	ng cause given in Part I.	23e. Did tobacc	o use contribute	to the cause of death?	
}	Hypertensiv	n			1 ☑ Yes	2 No 3 F	Probably 4 ☐ Unknow	<i>i</i> n
	- Hyperlipi de	mia			24a. Was an autopsy performed' 1 □ Yes 2 ☑	death?	autopsy findings available completion of cause of	le f
2	25. Was case referred to medical examiner?		/		ath (Check only one)			
	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🔯	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Sp	ecify)	
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac y)	ctory, office	28f. Location (Street City or Town, St		Rural Route Number,	
5	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occu tion and/or investiga	rred at the time, date and plac ation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)	_
	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mor	nth, Day, Year)	
	mderci BK	othe		DUSUSUN	Aus	ust 12,	ZWY	
	30. Name and address of person who co							
	FREDERICE B LOTION	MD = 10 No	rth Grien	1 Street Bai	more V	arylan.	1 21201	

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician AMBUST 2008 Sandra Carol Prysiazny 27:42FM /Medical 4b. City, Town, or Location of Death 4a. Factive Name (If not institution give sweet and number) Center 4c. County of Death Examiner imore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/09/1970 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2√F Months Days Hours Min. Maryland Director 219–88–3903 38 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations to be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 11 Marie Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 20 1 Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sue Carol Davidson Sam Roger Gillespie, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Marie Avenue, Baltimore, Maryland 21221 Sue Gillespie (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Pemoval from State 08/16/2008 Ridgedale Cemetery Rich Valley, Virginia 4 Donation 5 Dother (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A 21. Synature of Funeral Service Lic 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only or flons/that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 8 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): ACUTE RENAL FAILURE **Examiner** 7 DAYS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b SPINA BIFIDA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Unpatient funeral Date of Injury (Month, Day, Year) 27. Manyier of Death 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

LILIA CEBALLOS, M. D 7601 OSLER \$2. Registrar's Signature 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

29a, Certifier

31. Date filed_//

(Check only one)

29b. Signature and title of certifier

29c. License number

D258816

TOWSON, MARYLAND

DRIVE

29d. Date signed (Month, Day, Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 28e-f, perME, g882 8/18/08 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Raymond õ8 2008 10:25a [™] 08 Christina Linda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Hours 1□ M **%**□ F Months Days 58 Director 216-58-3015 04 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the McJical Experience out to profile of 1√ Yes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21207 Funeral **2807 Silverhill** Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XI If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify. Specify: ۵ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ukn College (1-4or 5+) Disabled Disabled N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise G. Taylor Henry O. Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Liberty Heights Ave, Baltimore, Md 21217 Vera Williams-Daughter 3908 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation 8/15/08 Baltimore, Md Metro Crematory Inc 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses Cala 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HSPHYXIA Physician due TO AS Too piration disease or condition resulting in death) /Medical Due o (or s a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown g ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 00 certificate 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner?
Yes 2 □ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending CHOCKINGON 1 DNatural 5 Pending investigation +00 a death. August 8,2008 anknows 1 □ Yes 2 No 2 Accident 24 hours a er death Funeral Director the 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | Adult Day Care 3 Suicide 28f. Location (Street and Number or Rural Route Number, Active or Town, State) 3630 Milford filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) tello MD irimble

Registrar

State

31. Date filed (Month, Day,

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2008

			Certificate of Death		eg. No.	20216
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	Funeral Director		5. Social Security Number 6. Sex 1 Months Deys Hours Min.	8. Date of Birth (Month, Day,	9. Bi	thplace (State or Foreign ountry)
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	show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	or 2	Director	10e. Street end Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	23a		300 WEST SEMILIARY AVENUE 21093		USA	
	terms	Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto F	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Baltimore, Maryland 21215-0020	parmit. Peges 1 end 2 should be filed within 72 hours aftar death with the Maryland Dapartment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, If a Medical Examiner must be notified at once.	ρ	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specific	HITE
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin	er	4a. Facility Name (If fot institution)	n, give street and number)	المال وتين	4b. City, Town, o	T Location of Death	7) : 41 4 /	4c. County of D	Death Ca
	Funeral		5. Social Security Number		(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	th year) 9.	Birthplace (State or Foreign
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	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral	11. Marital Status	12/Was Decedent E	Ever in U.S. 13	. Was Decedent of H	133 Hispanic Origin? (Sp	ecify Yes or No	14. Race - A	American Indian,
٥	or iter	/ Fur	1 Never Married 2 Mar	rried Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	10	If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, V Specify:	Vhite, etc.
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			23a. r art1. Enter the disease, o shock, or heart failure. Lis	r complications that caused t only one cause on each lin	th eah. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician (Medical		Immediate Cause (Final disease or condition resulting in death)			ROTTC	CARDIOI	MSCU	LAR DISC	Onset and Death
	/Medical Examiner			Due to (or as a	a consequence of):					
Ü	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a consequence of):					
8	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):					
68/6 0,	icate be executed physician and the burial-transit			Bus to (or as t	a concequantee on.					
-		Aedical	IS SEMALE.	u						
X P P	w requires that the death certif been signed by the attending should be detached for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	y		23d. Date o Month	•
o.	y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _				,
S, J	es that gned b	by Pt	Part II. Other significant condit	ions contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	tobacco use contribu	ite to the cause of death?
ord	require een siç nould b							10	Yes 2 No 3[Probably 4 Únknown
Vital Records,		Completed						24a. Was	an 24b. Wei ppsy prio ormed? dea	re autopsy findings available r to completion of cause of
Į			25. Was case referred to medical	al			26. Place of Dea	1∐ Yes	2 / Q No 1 □	Yes 2 No
	nysicia Ils cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA Oth			idence 6 □Other ((Specify)
n or	ing Ph After th uneral		27. Manner of Death 1 √Natural 5 ☐ Pendi			wo Wo		28d. Describe	how injury occurred	
DIVISION	death ctor: /	ficati	3 Suicide 6 Could		ıry - At home, farm, s	101]Yes 2□No	28f. Location (Street and Number of	or Rural Route Number,
<u>≥</u>	al or A s after al Dire	Certification:	4 ☐ Homicide deterr	building, etc	c. (Specify)	,,		City or To	wn, State)	, real real real real real real real real
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, and the funeral director director, and the funeral director director, and the funeral director director, and the funeral director director director, and the funeral director directo	Medical (29a. Certifier 1 Certifyi (Check only one)	ing Physician: To the best of I Examiner: On the basis of	examination and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	cause(s) and mann , date and place, and	er as stated. If due to the cause(s)
	o the vithin 2 to the comple	Med	29b. Signature and title of certific	and manner sta	itea.	29c. Lîcens			29d. Date signed (f	
)	,- > F 0		1/ Sin ('incle	u un	7	31136		August	4,2008
	2		30. Name and address of person	1 1 1 1		e, Print)	11.20 .	- 0x	BALTIN	4,2008 re, M) 21236
9	Sta	ite	31. Date filed (Month, Day, Year	WALLACO 32 Registra	ar's Signature	005 K	(LISKI)E	? ~!), /	SHU IME	-e, my 21256
	Regist		AUG 14		H A	10				

Phys /Me Exan

Funer Directo

/Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1- State Registrar Certificate of Death Reg. No. 2008 26278												
cia dica		1. Decedent's Name (First, Middle, Last) Mildred D. Sweeney 2. Date of Death Aug. 12, 2008 3. Time of Death 12:45au											
ine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Laurel Regional Hospital 4b. City, Town, or Location of Death Prince George's											
al or		5. Social Security Number 123-14-6829 1 M 2 M F 84 Yrs. 1 M Onths Days Hours Min. 2 M Onths Days Hours Min. 3 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 4 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days Hours Min. 5 M Onths Days											
	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1											
i	l o Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15806 Bond Hill Road 20707 USA											
1		11. Marital Status 1											
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. DO NOT use retired Own Home											
		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
ı		David Mason Nettie unknown											
		19a. Informant's Name/Relationship (Type. Print) Douglas Sweeney/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Anderson Drive Homer, New York 13045											
		20a. Method of Disposition 1 Removal from State 4 Donation, 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary 's Cem. 20c. Location - City or Town, State 8/16/2008 Cortland, New York											
A LINE		21. Signature of Funeral Service Licenses PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910											
1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart farlure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Aspiration 2 days											
r		Due to (or as a consequence of):											
	Pnysician/medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.											
		resulting in death) Last Due to (or as a consequence of): d.											
		IF FEMALE:											
		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Date of delivery Month Day Year											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No											
	Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No											
á	o l	25. Was case referred to medical examiner? 26. Place of Death (Check only one)											
F	2	1 Ag Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
		1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No											
	Certific	3 ☐ Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
N.W.	IA	29b. Signature and title of certifier D24721 29c. License number D24721 Aug. 12, 2008											
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Sadiq MD 14333 Laurel Bowie Rd Laurel, Md 20708											
31 Date filed (Month Day Year) 32 Benistrar's Signature													
/200		AUG 1 4 2008 Steven St Sports											

DHMH 17 Rev 1

Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Regina Scott рм August 12 2008 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1249 Maple Avenue Arbutus Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 XF 89 Yrs 08/15/1918 Director 212-03-6561 Baltimore, MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex miner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2X No Baltimore Director Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1249 Maple Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard C. Mason Alice Mason Reilly 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Stromberg (Daughter) 10392 Boca Raton Drive, Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Gardens 08/15/2008 Marriottsville, MD □Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** wee disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Tes 2 ☐ ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

B Hospital or Attending P 24 hours after death. Funeral Director: After t within 24 hours a To the Funeral L

29b. Signature and title of ce (Item 23a) (Type, Print)

alverton

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar 29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:00 KM August William Milton 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL BALTIMORE n/a 6. Sex 1 ★ M 2 ☐ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Director 216-24-7637 Yrs 3/24/1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 □Yes 2 No Directo Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1512 Langford Road Funeral 21207 United States 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Print News Media 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton William Sahm 2 Angela Chalmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other tra once. Mary Lou Sahm / Wife 1512 Langford Road Baltimore, MD 21207 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/12/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD Mailes T; 23a. Part 1. Enter the diseas , ... In the diseas that caused the shock, or heart failure. List only one cause on each line rifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death WEELS Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To ō 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE

State Registrar BHAVANDEEP

31. Date filed (Month, Day, Year)

BAJAJ

32. Registrar's Signature

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BALTIMORE, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John E. Scheihing 8:30AM rugust 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death. Examiner narles town ronsville Itimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 213-12-7774 Director 88 April 4, 1920 Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or pe 5534 Carville Avenue r than "natural", or Items 23: the Medical Examiner must Funeral 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced 1943-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Technician Defense 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Menta! I ant: If item 27 is marked o 2 John E. Scheihing Helen Harrigan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other tr John E. Schene Nephew 5534 Carville Avenue; Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 8-11-2008 Baltimore, Maryland Loudon Park Cemtery 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Se vice Lice 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Property Sping Due to (or as a consequence of): Physician Stenosis with Quadriplegia years disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Š cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 5 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1∐ Yes Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 N 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After or Attending 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident after death the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 0 29c. License number of person who competed cause of death (Item 23a) (Type, Pnnt) 30. Name Maid 31. Date filed (Month, Day, Registrar's Signature Year 1 4 2008

Registrar

08-06151 Mary Sullivan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 26282

			i - For State Registrar		Certificate of Death Reg. No.								eg. No.			
	Physicia		Decedent's Name (First		Mont					ate of Death South Day Year 0534 broken						
,	I Exami	ner	MARY PATR		Auç					2, 2008	0534 hrs					
			4a. Facility Name (if not institution, give street and number) 16823 York Road					b. City, To Monkto		ocation of I	Death		4c. County of Death Baltimore County			
1	Funeral		Social Security Number	6. Sex	7.	Age (In yrs. las	st birthday)	If Under		If Under	_	8. Date of Bi	rth (MM/DD/YYYY	g. Birth Foreign		
Į	Director		139-66-16 Usual Residence of Dece	Yrs	Months	Days	Hours	Min.	03/1	2/1961	Cour	ntry) N.J.				
	any														10d. Inside City Limits	
0	≜ ,	٦	MD BALTIMORE MONKTON										1 Yes 2 No			
4	and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene teath and Mental Hygiene from "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number		10f. Zip Code					10g. Citizen of What Country?						
3			16823 YOR		21111					USA	USA					
di .	ath with	Funeral	11. Marital Status 1 Never Married 2		B. Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Io- 14. Race - American Indian, Black, White, etc.						
	er de		3 Widowed 4	1	Yes 2	X No	specify:			Specify: WHITE						
	irs afi	ā	15. Decedent's Education	16a. Deceder	edent's Usual Occupation (Give kind of work done					16b. Kind of Business/Industry						
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5-0036	led within 72 Hygiene. I other than the Medical	Completed	5+ MEDICAL TEC								OGI	ST	MEDIO	CAL		
5-0	Hygie other		17. Father's Name (First,						18		,		Maiden Surname)		
2121	uld be fill Mental H marked c event, t	Be	THOMAS J.				.,					IA KE				
MD 2	Pages I and 2 should be filed within ent of Health and Mental Hygiene. Int: If item 27 is marked other traumatic event, the Med	To	19a. Informant's Name/ReCAILEIGH M		g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 YORK RD MONKTON, MD • 21111 •						Zip Code)					
<u>6</u> ,	es I and 2 s of Health ar If item 27 her trauma		20a. Method of Disposition		D f		lace of Dispor		e of cem	etery,		Date	20c. Location	- City or	Town, State	
Baltimore,	Pages 1 ient of 1- int: If i			Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: GREEN MOUNT CREMATORY 08/14/08 BALTO CITY, MD.											CITY, MD.	
霊	permit. Page Department of Important: injury or oth	1	21. Signature of Funeral		-		22.1	Name and	Address	of Facility		2 6 0	0110 00			
m	in In De		VIIICA	m			1	ENRY 5924	W. YÖE	JENI RK R	KIN: D M	о Зикто	ONS CO	2111	1.	
	nysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and													
	Medical xaminer		Immediate Cause (Final	disease a. M	ultipl	e inju									Death	
			or condition resulting in o	death) Due	to (or as a co	onsequence of):									
		ē	Sequentially list condition if any, leading to immedia		to (or as a co	onsequence of):		-	_						
,		miner	C. (Disease or injury that initiated consequence of):													
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,160,	ficate be execut g physician and s the burial - tra	ledi	IF FEMALE:			tcome of pregr							23d. Date of	of delivery		
876	40 00 12	M/us	23b. Was decedent pregn past 12 months?			h		etal death	3	Ectopic	pregnar	ісу	Month	-	Day Year	
Box 68	ne death certific the attending pred for use as the	siciar		Makeneye	4 Pregnar	nt at time of dea	nth	ther (Spec					4			
_	ne dea the a	by Phys			9 Unknow					in De		220 Did	tobacca usa can	tribute to	the cause of death?	
P.O.	Atending Physician: The law requires that the death certi death. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use as															
	quires en sign ald be													itopsy findings available		
oro	law requi has been 2 should	Completed										aut	opsy		completion of cause of	
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<u> </u>	cian: The certificate ector, page	Be	25. Was case referred to examiner?		nitel:			P1	- 1	of Death (
of Vital Records,	hysic this	٥	1 ✓ Yes 2	No		patient 2	ER/Outpatier			Other ₄	,	Home 5	Residence 6			
Jo.	ling Ph After t funeral	ä	27. Manner of Death 1 Natural 5	D di	28a. Date of (Month, D	Injury Day,Yaar)	28b. Time of			yatWorkî es 2 X	- 11	by mot	or vehic	:le w	ıbject struc hile in	
. <u>io</u>	Attend death ctor:	Sati	2 X Accident	Pending Investigation	8/12/		4:51					her ho		har or Di	ıral Route Number, City	
Division	ospital or Attene hours after death ineral Director: y filled in by the	Certification:	3 Suicide 6	Could not be determined		of Injury - At ho	ome, rarm, str	et, ractory	onice bi	Jilaing, et	- 1	or Town	State)			
	ospite hours unera ly fillk		4 Homicide 10025 Tork Rd Hereford, Fib													
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
	To wit	Me	and manner stated. 29b. Signature and title of certifier						29c. License number					29d. Date signed (Month, Day, Year)		
			South 8	nitte.	1 nns	7			O.C.1	И.Ε.			August 12	2, 2008		
1 Ch	Dend	30. Name and address of person who completed cause of death (Item 23a)														
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201																
		tate	31. Date filed (Month Da	Year 2008	37 Reg	istrar's Signat	*	AR)								
	Regis		AUG	T = \$000	June		19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10, 2008 Kaymond AUGUST 10:10P M Mnippa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 58 Director 3-1949 216-52-4823 Usual Residence of Deceden MD 10a. State ral", or items 23a or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 'natural", or items 23a 21229 6114 Cooks Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 □Yes 2 □No If Yes, Give X Year or Dates: 1 □Yes 2 No Specify ò Specify: Black 3 ☐ Widowed 🏋 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Men al Hygiene. College (1-4or 5+) Display Craft Inc. Carpenter 12th grade is marked other and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Rebecca Smith Leonard Whiting Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. P. ges 1 and 2 s
Department of Health ar
Important: If item 27 is
any injur. or other trau 21239 1207 Limit Ave, Baltmore, Md Katrina Brownson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nation | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) 8/10/08 |Baltimore, Md Zion 21. Signature of Funeral Service 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Du to (or as a consequence of): disease or condition resulting in death) da. /Medical Examiner 3 months Lichasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a P.O. 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vision of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marce hallo August 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Chatham Beltimore, Md 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) ate of Death **Physician** 9 1001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CGdamy Kd 97 045 6 On 11/11 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** . 1925 1□M 2XF 216-48-4013 82 Director Venezuela Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wohe ? Is marked other than "naturel", or items 23s or 28s-1 shot traumatic event, the Medical Examinating the notified at 1 ☐ Yes 2 No Catonsville Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Academy Road 21228 Venezuela Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Venezuelan White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home permit. Peges 1 and 2 should be filed.
Department of Health and Mental Hygis Important: If Item 27 is marked any Injury or other 17. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Santana Veitia Josefa Albornoz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Harvey, Daughter 510 Academy Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Woodlawn 08/18/08 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Woodlawn, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor MacNabbo Funeral Home, P.A. <u>301 Frederick Road Catonsville, Maryland 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 91 disease or condition resulting in death) /Medical Due to lot as a consequence of): Examiner 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 1110 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has al director, page 2 autopsy performed? Yes 25 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA ctor; After this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death 1 Yes 2 No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Ery Kazlowino 0805 HICKSI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 21 per dwg e882 8-14-08 yt 13-14-ealth and Mental Hygiene 2.0.0.0

			For State Registrar			- wiaryiaii	Ce.	rtificate of	Death		Reg. No.	2008	26285	
	Physicia	an	1. Decedent's Name		,					2. Date of De Month	Day	Year	3. Time of Death	
Dag	/Media	cal	Emma Be11 4a. Facility Name (If	.	1	ANGUST		2008	0715AM					
	Examir	ner				,		4b. City, Town, or	r Location of Deat	n		County of Death	1 =	
	Funeral		5. Social Security Nu		ge (In yrs. last birthday) If Under 1 Year If Und			8. Date of Bir	th	9. Birtho	place (State or Foreign			
	Director		216-46-18 Usual Residence of I	98	Sex 1 □ M 2 💢 F				Months Days Hours Min. Aug			Cour	yland	
	/land	ctor	10a. State	10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
	Mary I-f sh		MD	Baltimo	re		Tows	on					1 ☐ Yes 2 No	
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, ir & Medical Examirer must be notified at	irec	10e. Street and Num	ber				10f. Zip Code			10g. Citiz	en of What Cour	ntry?	
		al	1055 W.	Joppa Ro	ad #201				21204			USA		
	ems	Iner	11. Marital Status		12. Was Dece Armed Fo	dent Ever in U.S	S. 13.	Was Decedent of H		Specify Yes or No)- 1	4. Race - Americ Black, White,	can Indian,	
5-0036	ours after ral", or it	Completed by Funeral Director	1 ☐ Never Marrie 3 ☐ Widowed 4		1 □Yes If Yes, Giv Year or D	2 ▼ No		1 □Yes 2 No		o riioan, oto.,		Specify: whi		
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Ž	should and Men marke	To								tta Clas				
Maryland	d 2 sl th an 7 is r traur		19a, Informant's Nar Csrl Wagr					ng Address (Street						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ensiting range any injury or other traumatic event, the Medical Ensiting range and once.		20a. Method of Dispo		5 E	20h. Pl		W. Jopp		201 Tows		MD 2120 cation - City or To		
Baltimore,			1 ☐ Burial 2 ☐ 4 🕅 Donation	Cremation 3 ☐ 5 ☐ Other (Speci	fy)	State		sition (Name of matory or other plac	. !					
Bal			21. Signature of Fun	neral Service Lice Onald S.	Wade, D	irector er dvr	B	2. Name and Addre State Ana altimore.	ss of Facility tomy Boa: MD 212	rd 655 W	. Bal	ltimore	Street	
- Marie Control	tificate be executed By Medical Examiner By the burial-transit		Ronald S. Wade, Director Per dvr State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death disease or condition resulting in death) SUBD WATE Approximate Interval Between Onset and Death DATE Approximate Interval Between Onset and DATE Approximate Interval Between Onset and DATE APPROXIMATE Approximate Interval Between Onset and DATE Approxim											
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	rtifica ng ph as th							1	(John)	10,10				
O. Box	Physician: The law requires that the death cert rule certificate has been signed by the attending director, page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 0 9 □ Unknown	nonths?	23c. If yes, out 1 ☐ Live t 4 ☐ Pregi 9 ☐ Unkn	death 3[□ Ectopic pregnanc □ Other (specify)	Sr. Sh.	2	23d. Date of delivery Month Day Year				
σ.			Part II. Other signific	cant conditions	contributing to de	ılting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute to the cause of death?				
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Vital		Be C	25. Was case referre	ed to medical					26. Place of De	1 ☐ Yes ath (Check only		1 ☐ Yes	2 LIN0	
>	ding Physician: n. After this certific funeral director,		examiner? 1∭ Yes 2 □ N	No	Hospital:	npatient 2 🔲	ER/Outpatie	nt 3 DOA Oth		dome 5 ☐ Res		□Other (Speci	f _V)	
οt	ding Ph J. After th funeral	i.	27. Manner of Death		28a. Date	28a. Date of Injury 28b. Time of 28c. Injury at					how injury			
io	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	atio	1 ☐ Natural 2 ☑ Accident	5 ☐ Pending investigatio	n AVGVST	2,2008	500	M Mor	Yes 2 No	FALL	_			
Division		Certification: To	3 ☐ Suicide 4 ☐ Homicide	eet, factory, office 28f. Locat			ntion (Street and Number or Rural Route Number, or Town, State)							
		Cer				JOPPE	PPA AD PONSON MD							
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.									stated. o the cause(s)		
	Nothi Vithi Com		29b. Signature and title of certifier Alcumom					29c. License number D 58303 RUGUST 8 2008 e. Printy LULUS ST TOWSON ND 21204					-	
			30. Name and addre	ss of person who	completed caus	e of death (Item	23a) (Type,	Print)	1 15	PIN SAN	M	7 7120	24	
	Sta	ite	31. Date filed (Mont	UG I 4	2008 32.	gistrar's Signat	lure	Carp.	- 4/ /	J 0, V	- 77		/	
DH	Registr MH 17 Rev 1/2	- 1			1		5 19							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jennie Moy Wong August AM 2008 6:50 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 213-42-3996 1 □ M 2 💆 F 93 Jùne 18, 1915 Washington DC Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore 10e. Street and Number 3105 Gilford Avenue 10f. Zip Code 10g. Citizen of What Country? 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Chinese 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David-Moy Chee Nie Mary-NG Juie Hie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice W. Lee / Daughter 3105 Gilford Ave, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 08-23-2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 □ Yes 2 No 2 💢 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

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Medical Certification: To

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Physician

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Funeral

Director

show

Department of Health and Mental Hygiene. Important: jor Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Expiriting must be notified at

Baltimore, Maryland 21215-0036

6:50

13,

AUGUST

/Medical

10a. State

MD

Director

Funeral

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and burialattending physician for use as the burial signed by the a , page 2 s has

certificate director. this

Vital Records, P.O. Box 68760,

Division of

JENNIE WONG

requires that the death certificate be executed Hospital or Attending Physician: The funeral After death. the hours after deatl uneral Director: filled in by

25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier (Check only

one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 31. Date filed (Month. State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Registrar

24 hours a Funeral C

within 2

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per dr., g882, 08/44/08/amb of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 20:30 PM R. WHITE CLARENCE 08 2008 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 3116 23618 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination ust be notified at once. Funeral Director MN BALTIMORE MUNDALK 1 ☐ Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 21222 LIBERTY USA Was Decedent Ever in U.S. Armed Forces? 1 Nayes 2 No 1942 -If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ethlehem Elementary/Secondary (0-12) College (1-4or 5+) 10 Ò NELDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 RENT HUNTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ELSIE Parkusy Dundalk mo 21222 LIBERTY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/10/2008 CARROLL Crem WINFIELD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBNW FH & MON Co. SYKESVILLE Road ELDERSBURG-MO 21784 It . Enter the dise se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY 1 HOUR /Medical Due to (or as a consequence of): **Examiner** 2 YEARS RIGHT HEART PAILURE SIDED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician; The law requires that the death certificate be executed Congestive Heart Failure 2 years attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

11/

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

BANKOVA, M.D.

Year)

AUG 14

DHMH 17 Rev 1/2001

29c. License number DES-000

EASTERN AVENUE, BALTIMORE, MD 21224

AUGUST 08, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day EARL Month Year 1745 M AUGUS /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore nder 1 Year | If Under 24 Hrs. amaritan Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 1 2 F Months Days Yrs. **Jirector** 358-*64-5*87 42 2.16-1964 Usual Residence of Decedent r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** WD 14 Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with r than "natural", or items 23a or the Medical Examinar must be a 21239 1259 Walker Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Armo 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ■Never Married 2 ■ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 **☐ No** If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Works 124 Baltimore 7 is marked other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Adams, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health e of Disposition (Name of Date 20c. Location - City or Town, State Beverly 20a. Method of Disposition item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important; If it any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Son Comptery 8.16.2008 Pulas Ki, TL

22. Name and Address of Facility Vaugna C. Oregan Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) Henderson Cemetery 21. Signature of Funeral Service Licensee Vaughn C. Dreene

4905 York Pro Baltimore

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Immediate Cause (Final Physician inknow disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause I Unsease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ (ABIETES MECLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 → Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12008 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHARAN, GOOD SAMARITAN HOSPITAL, MD 21239 KALATHIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 5 2008 Registrar

DHMH 17 Rev 1/2001

08-06199 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ulyesses Ashe State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar , Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 13, 2008 1730 hrs Medical Examiner esses 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number 3023 Frisbee Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours Director Country) 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f shov notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e, Street and Numbe Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Yes Yes. Give Year 4 Divorced Widowed Yes 2 X No specify: marked other than "natural", c event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be une 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m r traumatic e Son) 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition matory or other place) Important: If it injury or other Baltimore 2 Cremation 3 Removal from State Donation 5 Other Specify gnature of Funeral Service License sal Joseph Part I. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit requires that the death certificate be executed Physician/Medical & 20=C Der F.H G-882 <u>8/25/08 reb</u> physician a UNPENDED AMENDED item 20b O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 V Probably 4 Unknown Division of Vital Records, P. Yes 2 24a. Was an 24b. Were autopsy findings available s certificate has b rector, page 2 sh autopsy prior to completion of cause of performed? death? Yes 2 ✔ No 2 After this certific funeral director, p To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifut completely filled in by the funeral director, 1 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other, Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes Certification: To 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Yes 2 Director: J Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide

State

Medical

29b. Signature and title of certifie

Tasha Greenberg MD.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 14, 2008

Registra

30. Name and address of person who collol ted cause of death (Item 23a)

and manner stated

Men

Assistant Medical Examiner

Registrar's Signature

Amend #20a Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :10 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons withwest andallstown Baltimar HOSPICE 8. Date of Birth Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Days Year) Months Hours Min 240-24-3898 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD 1 ☐ Yes 2 ☑ No Director Winas tima 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. Specify: Blace 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) 124 ears Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maga Known ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) yons Run Cir. McDanie Owings Mills, MD 2117
20c. Location - City or Town, State and 20b. Place of Disposition (Name of capacitery, Carine Lotte Cemetery 8/25/08 20a. Method of Disposition 1**X** Burial 2.2€ 3 Removal from State Baltimore, MD Injury 4 ☐ Donation 5 ☐ Other (Specify) Voughn C. Breene Runeralsus 21. Signature of Funeral Service Licensee Vaire Randallstown, MS 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEWMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off The law requires that the death certificate be executed ysician and e burial-tran O. Box 68760, § Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No the detached 9 Unknown 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Vita 2 **X** No 1 □Yes 2 No 1 TYes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) SUNSONS Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To itos Pice of After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTENSTOWN 25 MAIN STREET Elirah 31. Date filed (Month, Day, Year)
AUG 1 5 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Patricia Mary Allen 2008 1:45PM /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F Yrs Director January 2, 1920 017-03-7718 88 Massachusetts Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 🙀 No Maryland Montgomery <u>Bethes</u>da 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Funeral 9817 Singleton Drive 20817 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Completed by Specify. 3 Widowed 4 Divorced "natural" WWII White th and Mental Hygiene.
7 is marked other than "natur traumatic event, it medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Patrick Edward Clark Mary Patricia Frawley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Patricia Allen Graves/ Daughter 9817 Singleton Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico 20a Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) National 21. Signature of Fureral Service Licensee Bethesda-Chevy Cha M00335 Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cirrhosis Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perforn 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2∏No 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

68760, 5% Division of Vital EN, PATRICI

State

Medical

Registrar

29b. Signature and title of certific

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	Cert	tificate of	Death		Re	g. No.	00 2023
Physician/	Decedent's Name (First, Midd					Date of Death Month		3. Time of Death
ના Examine	vavaa racke					August 5,	2008	0920 hrs
	4a. Facility Name (if not institute 300 Burnside Street	on, give street and number)	4	 b. City, Town, or L Annapplis 	ocation of De	ath	4c. County of De	
_	5. Social Security Number	6. Sex 7. Age (In yrs. Ia	ot histheless)	If Under 1 Year	If Under 24I	Lies To Date of Birt	h(MM/DD/YYYY) 9.1	
Funeral Director				Months Days	+	/lin	For	eign Washington D.C.
	231-06-1352 Usual Residence of Decedent	1 X M 2 F 46	Yrs.			02/19/	1962	v.c.
any	10a. State 10b. County	10c. City,	Town or Location	on			-	10d. Inside City Limits
* *	MD Anne.	Arundel Ann	apolis					1 Yes 2 X No
Aaryland 28a-f show 1.at once. ector	10e. Street and Number	Number Am	mports	10f. Zip Code		10	g. Citizen of What C	ountry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Mrdiral Ex-miner must be notified at once. To Be Completed by Funeral Director	810 Severn Au	10 NII 0		21403			U.S.A.	
with ms 23	11. Marital Status	12. Was Decedent Ever in U.S		Decedent of Hisp		Specify Yes or No-	14. Race - Am	erican Indian, Black,
r death with or items 23 must be no	1 Never Married 2 N	1 Yes 2 X No		es, specify Cuban,		erto Rican, etc.)	White, etc	
s after	3 Widowed 4 X Di	vorced If Yes, Give Year or Dates:		Yes 2 X No			Specify: Wh	
hours after "natural"; Exeminer		ecify only highest grade completed)) College (1-4 or 5+)		's Usual Occupations of working life.			16b. Kind of Busines	s/Industry
5-0036 ed within 72 hour tygiene. other than "nature. Completed	Liementary/Secondary (0-12)	2	Manta	roo Eina	en i un		Book E.	tato
5-00 led with Hygiens other the M	17. Father's Name (First, Middle		Morage	<u>rge Finar</u> 11		ame (First, Middle, N	Real Es	iare
21215-0036 uld be filed within 72 Mental Hygiene marked other than cevent, the Midical To Be Comple		umin Blair			Brenda	. Curtin		
D 21 nould men is man	19a. Informant's Name/Relation	ship (Type, Print)	19b. Mailing	Address (Street			ber, City or Town, St	ate, Zip Code)
- P = E E	Brenda Xander						Pennsylvan	
5 2 E E E	20a. Method of Disposition 1 Burial 2 X Cremation		Place of Disposi rematory or oth	tion (Name of cem er place)	netery,	Date	20c. Location - City	or Town, State
imore Pages 1 ment of H tant: If it	4 Jonation 5 Other S	Specify: Met	ropolit	tan Crema	itory 8	3/12/08	Alexandr	ia, Virginia
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr	21. Signature of Funeral Service	e Licensee (22. N	ame and Address	of Facility	Pierce Fi	uneral Hon	e, Inc. inia 20110
hysician	23a, Part I, Enter the disease, o	or complications that caused the death.	Do not enter th	e mode of dving.	STRE	ec or respiratory arm	ssas, Virg	Approximate Interval
Medical	failure. List only one cause	e on each line.			000000000000000000000000000000000000000	o or toophatory and	out, officially of fice it	Between Onset and Death
⊏xaminer	Immediate Cause (Final disease or condition resulting in death)	 a. Contact Gunshot Wound Due to (or as a consequence of 						
	Sequentially list conditions,	b						
ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
nsit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
		d						
760, Grate be executed by the burial - tra	UNPENDED	AMENDED						
8760, ifficate be ag physici sthe buri		the 23c. If yes, outcome of pregr		tal death 3	Ectopic pre	anancy	23d. Date of deliver Month	very Day Year
Sox 687 death certiff te attending I for use as t	past 12 months?	4 Pregnant at time of dea	oth	ner (Specify)		-grandy		24)
Box ne death o the atten red for us		9 Unknown						
s, P.O. B. irres that the de signed by the d be detached f		itions contributing to death but not re	esulting in the u	inderlying cause gi	iven in Part I.			to the cause of death?
Juires quires en sign ald be						_		Probably 4 Unknown
Records, The law require are has been signage 2 should bo						24a. Was autop	osy prior	autopsy findings available to completion of cause of
							rmed? death 2 ✓ No 1	Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medic	Hospital: 1 Innation 2			of Death (Che			
Physical Circles	1 Yes 2 No	28a. Date of Injury	28b. Time of Ir	3 DOX			Residence 6 🗸 O	her: Scene
Division of Vital Records, lat or Attending Physician: The law requirers after death. "I Director: After this certificate has been silled in by the funeral director, page 2 should bertification: To Be Completed	1 Natural 5 Per	rounding FOUND:	FOUND:		y at Work? ′es 2 ✔ No	Subject sho	how injury occurred t self	
ivision of or Attending or Attending after death. Director: Aft in by the function:	2 Accident Inve	estigation Aug 5, 2008	0855 hrs			28f Location (Street and Number or	Rural Route Number, City
Divisor Applied or A hours after meral Directly filled in b Certific	3 ✓ Suicide 6 Cou 4 Homicide dete	ermined (Specify) Park/Recre		or, ractory, omco b	anding, etc.	or Town, S		
Hospi 4 hou Fune ely fil	29a. Certifier 1 Certifying F	Physician: To the best of my knowledge		red at the time, da	te and place,			
To the Ho within 24 h To the Fun completely	one) 2 Medical Ex.	aminer: On the basis of examination ar						
FSFS	29b. Signature and title of certification			29c. License	number		29d. Date signed (Month, Day, Year)
	Patu (1.	· Molle m		O.C.N	И.E.		August 6, 200	8
28		on who completed cause of death (Item	,	444 5 5				
	Patricia Aronica-Polla			111 Penn Sti	reet, Baltin	nbre, MD 2120	1	
State Registra		32. Registrar's Signatu	k /_	100				
MH 17 Rev 1/2001	Aug 2 c	LOUI JUSTINE L	ORIGINA	L	·			
20000		ELO A AIR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3008 atherine man /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSDIC Cis 0 imonium If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 9. Birthplace **Funeral** 1 M 2 F 215-12-1688 Days Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, Ite Madical Examinar must be notified at 1 □Yes 2 No Directo 0000 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □Yes 2 No 21215-0036 Specify. ģ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. chemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 1.5 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Forest namo NOCI Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1/2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bol Air Memorial Gardens 8/16/08 Bel Air MD 22. Name and Address of Facility Chapel + Cremation Secules Bolding e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. HILL MD 21020 23a. Part 1. Enter the diseashock, or heart failure Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of **Examiner** Corcestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No a Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifica etely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1∐Yes 2∏XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural
2 ☐ Accident 1 ☐ Yes 2 ☐ No Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUGUST

KATHERINE BELLMAN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

Beyer, SHIRLEY R.

State of Maryland / Department of Health and Mental Hygiene State Amend 18, perFH g882 8/15/08 TT / Amend #18perDVR G882 TT Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 10:55 AM HIRLEY AUGUST 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICAL ARUNDEZ WRNIE ANNE 8. Date of Birth (Month, Day, Year) 3-12-1951 If Under If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** Hours Months Days 1 □ M 2 🕅 F 217-52-3576 57 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 127 Louise Terrace 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: ò White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home maker Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williford Raymond Gerald Henrietta Josephine Fuka ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7910 Silence Shadow Ct #J Glen Burnie MD 21061 Mr Timothy Guinn / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Donaldson Crematory 8/12/2008 Odenton 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley Ruddick Funeral Home 21. Signature of Funda Service Lice M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Physician beauth.
Funeral Director: After this certificate has been signed by the attending physician and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 ☐ No 3 ☐ Probably 4 🕏 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 1 ☐ Yes neral Director: After this certific filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the within To the 29c. License number 9d. Date signed (Month, Day, Year) 29b. Signatule and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), TRIA 106 (A) 31. Date filed (Month, Day, agistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-06077 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene George Blain 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0000 hrs August 9, 2008 ব Examiner M٠ 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1700 blk. N. Bradford Street **Baltimore City** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours Director Country) 6-90-9915 2 F 1 X M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 'n 10a. State 10b. County 1 X Yes 2 No 28a-f show Itimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe s 23a or 28a-Funeral Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 12, Was Decedent Ever in U.S. 11. Mantal Status If item 27 is marked other than "natural", or items nor traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Yes Divorced If Yes, Give Year Specify: Yes 2 No specify: Widowed 4 ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print Grandmother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ other traumatic 20b, Place of Disposition (Name of cemetery, 20a. Method of Disposition. crematory or other place) X Burial 2 Cremation 3 12008 Donation 5 Other Specify 5 22. Name and Address of Facility
JOSEPH L. RUSS Signature of Funeral Service Licenses tuneral. WNorth Approximate Interval or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication failure. Just only one cause on each line Physician Between Onset and Viedical Death a. Gunshot wounds (2) of head Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Box 68760, ne death certificate be e 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o <u>چ</u> Yes 2 No 3 Probably 4 ✔ Unknown ₾. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has 2 s performed? death? No 1 V Yes 2 No ✓ Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: of Vital Be examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient Inpatient this 1 Yes No 28a. Date of Injury (Month, Oay,Yea Unknown 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot Division Unknown Yes 2 V No Pending Director: Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 3 Could not be Suicide or Town, State) 1700 blk. N. Bradford Street, Baltimore City, Md determined (Specify) Local Street To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME O.C.M.E. August 9, 2008

State Registrar 111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar Signatur

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day Year)
AUG 1 5 2008

08-06023 UNK UNK

Mr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- For State 3. Time of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2303 hrs August 6, 2008 Kober Examiner 4c. County of Deal 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Mayland Yrs Director 2 213-25-5028 Usual Residence of Decedent 10d. Inside City Limits loc. City, Town or Location 10b. County 1 Yes 2 No Manvian Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 2 Never Married Specify: Blac Yes Yes 2 No specify: "natural", or Divorced If Yes, Give Year 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) þ 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Cashier than 10 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) -mother item 27 is 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Itimore, 2 Cremation Important: injury or oth Donation 22. Name and Address of Pacility al Service Licen 21. Signature of Fulny oximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ween Onset and hysician failure. List only one cause on each line. **Medical** a. Multiple Gunshot Wounds Immediate Cause (Final disease _xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical **AMENDED** UNPENDED tending physician use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Month Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months? Fetal death Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Completed by 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Residence 6 Other: Hospital: 1 Inpatient Nursing Home 5 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27 Manner of Death Subject shot Certification: Aug 6, 2008 2220 hrs Yes 2 ✔ No Natural Pending the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1300 block Bloomingdale Road, Baltimore, MD Could not be Suicide determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 7, 2008 O.C.M.E. 30. Name and address of person who completed causa of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29ate of Maryland 200 coarments the alth and Mental Hygiene 26298 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Year :53 PM Beora Blount 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSA: tal Baltimore Bultimore Sinai 5. Social Security Numberunk If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 ☐ M 2 🛱 F Days Feb 28, Director 78 1930 North Carolina Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Evantinar must be notified at MD Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3624 Cottage Avenue 21215 USA Funeral unk
12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | MNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 1 and 2 should be 1 Health and Mental James Good 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a 4025 Frederick Avenue #308 Baltimore, MD Jessie Rice/cousin 21229 timore, important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state ce Licensee S. Wade 21. Signature of Euneral Serv ROTIAL d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Par II. Enter the disease, or confrical is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate a case (Final disease are case) (Final disease are case). Approximate Interval Between Onset and Death **Physician** arge Brain disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as t attending for use as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 be 2 No 3 Probably 4 Unknown 1 🗌 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 (I) M Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Hospital: 1 npatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) မ RES-0000 July 19, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA MD, SINATHOSPITAL OF BACIMONE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 15

2008

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32 Registrar's Signature

08-06173 Kimberly Brownina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26299

erry browning		- For	State	510	ale of t	viai yia		Certif	icate	of E	Death					Reg. No.			- 15-15	
Physicia ⊶l Examin	n/		Decedent's Name (First, Middle,Last) KIMBERLY LYNN BROWNING											Date of De Month August 1	2, 200			Time of Death 1630 hrs		
— į Examin		4a. F	acility Name (if	f not institution	n, give stre	et and nu				1	. City, Tov Westm		cation of		5	C	c. County of Carroll			
Funeral Director	7	5. So	ocial Security N	lumber	6. Sex		7. Age (Ir) Yrs.	If Under Months	1 Year Days	If Under Hours		3. Date of E JUNE			Coun	olace (State or F try) YLAND	oreign
any			al Residence of State	Decedent 10b. County			10	c. City, To	own or Lo	cation	n								0d. Inside City I	
*		MA	ARYLAND		LL		1	WESTN	AINS'			2040				10a. Cit	tizen of Wh			21.140
re Maryland or 28a-f show fied at once.	Director		Street and Nu 135 SYK		E RD						10f. Zip (TED S	TATE	ES	
275-0036 be filed within 72 hours after death with the Maryland nntal Hygiene. raked other than "natural", or items 23a or 28a-f she raked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral D	11.1	Marital Status X Never Marri		12			er in U.S.		If Ye	s, specify	Cuban,	Mexican,	n? (Spec Puerto R	cify Yes or ican, etc.)	No-	White	e, etc.		
after dez	by Fu		Widowed		vorced If Y	es, Give Ye	ar		ISO Doc	edent	Yes 2	ccupatio	on (Give k	ind of wo	rk done	16b.	Specify: . Kind of Bu			
72 hours an "natura	Completed b	15 E	Decedent's Elementary/Sec				1-4 or 5+		durii STU	ng mo	st of work	ing life.	DO NOT	use retire	d) -		EDUCA	ATION	1	
5-0036 Hed within 72 Hygiene. Jother than	dmo	17	Father's Name	(First, Middle	e, Last)					_		1					en Surname	:)		
21215- uld be filed Mental Hyg marked of	BeC	1 1	GARY L.	BROWN	NING,				1			/01	KATH	IE L	. RUD	DICK	City or Tov	vn, State,	Zip Code)	
2121 hould be fi nd Mental is marked	Ţ	19a	a. Informant's N				/ FAT	HER								ITNST	CER. N	10 21	L157	
iore, MD 21-215-0036 gges I and 2 should be filed within 72 hours after to fleathh and Mental Hygieine t: If item 27 is marked other than "natural", other traumatic eyent, the Medical Examiner			a. Method of Di	isposition				20b. P	lace of D rematory	isposi or oth	ition (Nan ner place)	e of cen		AUG	Date UST 1	6	c. Location	- City or	Town, State	LAND
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other t		21	Donation Signature of F	5 Other uneral Servi	Specify: e Licensed	9		UAF					of Facilit DDTCK	S.E.	ERAL GLEN	HOMI	ENIE;	A MD 2	21061	
Physician	-	23	a. Part I. Enter	the disease,	or complica	ations tha	t caused t	he death.	Do not e	nter t	he mode	of dying,	such as o	ardiac or	respirator	y arrest,	shock, or h	eart	Approximate Between On Deat	set and
Medical aminer			failure. List o imediate Cause condition resu		se a.M	ulitple E	Blunt Fo								,				Dog	
	Jer	- 1	equentially list any, leading to ause. Enter Un	immediate		ue to (or a	s a conse	quence of	ī):											
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ox 68760, eath certificate be executed rattending physician and for use as the burial - transit	Man.	SICIAIL/ME 23	b. Was deceded past 12 mon	ent pregnant i	n the	1 Liv	es, outcon ve birth regnant at		2		etal death		Ector	oic pregna	ancy		23d. Date Month			/ear
Box 687 Le death certific the attending F		≥ા	Yes 2				nknown ng to deatl	a but not r	reculting	in the	underlyir	a cause	given in I	Part I.	23e.	Did toba	cco use co	ntribute t	o the cause of d	eath?
, P.O. ires that the signed by	ocional d	함	art II. Other si	gnificant co	nditions	contributir	ng to deat	1 DUI HOLI	esulting		andony				1	Yes			obably 4 u	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate ly within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys	z silouiu oc	Completed														Was an autopsy perform Yes 2	ed?	b. Were a prior to death?		available cause of
tal Rec	, page	5	5. Was case re	oformed to me	dical T				_			26.Pla	ce of Dea	th (Check	only one)					
/ital sician:	S 6	a '	examiner?	2 No		ospital: 1	Inpati	ent 2	ER/Ou	tpatie	ent 3	DOA	Other ₄		ing Home		esidence		ner: Scene	
Division of Vital lal or Attending Physician: rs after death.	ineral	⊢	27. Manner of D	Death 5	Pending	Aug	Date of Inj Month, Day, 12, 200	ury Year) S	28b. T 1614		of Injury		Yes 2		Driv	ant aut er	w injury oct to truck (Ollision		-t City
Division of Atters and or Atters after dea	ed in by th	흹	2 Accider 3 Suicide	6	Investigation Could not I determined	28e. (Spe	Place of I	cal Stre	eet						or T Deer Pa	own, Sta ark Roa	ate) d and Boll	inger R	Rural Route Nui oad, Westmin	ster, MD
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /			4 Homici 29a. Certifier (Check only one) 2		ng Physici Examiner	an: To the	e best of r	ny knowle amination		ath oc nvesti	curred at gation, in	he time, my opin	, date and ion, death	place, a	nd due to the	ne cause e, date a	(s) and man			
To the transfer of the transfe	COIN	Medical	29b. Signature			and man	ner stated	2)				29c. Lic€	ense numl				29d. Date August	signed (i	Month, Day, rea	r)
<i>m</i>		-	30. Name and			completed	cause of	death (Ite	em 23a)	1	11 Pen	n Stre	et, Balti	more,	MD 2120					
7)	St	ate	Russell 31. Date filed	Alexander	Year)	- 1;	32. Refist	rar's Sign			book		-,							
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08-06175 Carl Vincent Bohn, II

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2008 25300

rl Vincent Bohr	1	State of Maryland / Department For State Certificate		ygiene Reg.	No.	
Physicia		egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
' Examin		Carl Vincent Bohn, III	West Name and Name an	Month D August 12, 2		1145 hrs
	1	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death Baltimore Cou	
	4	2292 Lowell Ridge Road	Parkville	- In Date of Birth	MM/DD/YYYY) 9. Bit	-
Funeral	3	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24Hr Months Days Hours Min	1	Forei	gn
Director		212-42-2202 1X M 2 F 64	Yrs.	11-15-1	943	ountry) Maryland
è			ocation			10d. Inside City Limits
T 50 M			kville			1 Yes 2 X No
Maryland 28a-f show any d at once,	황	Maryland Baltimore Co. Par	10f. Zip Code	10g	. Citizen of What Cou	intry?
he Ma or 28	Director	2292 Lowell Ridge Road	21234		United St	tates
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.			. Was Decedent of Hispanic Origin? (\$	Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
death ir iten	Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puert	o Ricali, etc.)	1.0	ni to
after	2	or Dates:	Yes 2 No specify: edent's Usual Occupation (Give kind of	Euradi dono I d	Specify: WI 6b. Kind of Business	nite
hours 'natu	E -		ng most of working life. DO NOT use re		ob. Nina of Edsiriess	/industry
36 hin 72 e. than	ble	12 yrs.	Salesman		Sale	es
5-00 ed with	Completed by	17. Father's Name (First, Middle, Last)	18.Mother's Nan	ne (First, Middle, Ma	_	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	8	Carl Vincent Bohn, Jr.	Marga		Reed	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than aumatic event, the Medica			lailing Address (Street and Number of			
			007 Cocan Way Ell	<u>kridge, M</u>	20c. Location - City of	21075 or Town, State
S 45 = 2		1 Burial 2 Y Cremation 3 Removal from State crematory	or other place) Service Corp. 08	/15 /2000	Towson	Manyland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	1		22. Name and Address of Facility)5 Harford	
Bal perm Depa Impo injur	-1	21. Signature of Euneral Service Licensee Michael E. Canapp	Leonard J. Ruck.		ltimore, M	
rysician		23a. Part I. Enter the disease, or complication, that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
√ledical Examiner	-	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic C	Cardiovascular Disease			Death
Examine		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated colored resulting in death). Last Due to (or as a consequence of):				
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.				
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760, cate be physica he buri	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	1
Box 6876 ne death certificate the attending phy	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic prec Other (Specify)	nancy	Month	Day Year
30X death he atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (opeary)			
O. I at the d by th	/ Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.			to the cause of death?
P.O.	d by			-		robably 4 Unknown
of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should t	ompleted			24a. Was a autops	sy prior t	autopsy findings available o completion of cause of
ecc The lay	mo			perfor		
Vital Reco ysician: The la his certificate ha director, page 2	BeC	25. Was case referred to medical	26.Place of Death (Che			
Vit hysica this call dire	70 E	Tes 2 No			Residence 6 🗸 Ot	her: Scene
J of Jing Ph	.:	1 Month, Day, Year)	ne of Injury 28c. Injury at Work?	280. Describe r	ow injury occurred	
ivisior I or Attend after death Director:	cati	2 Accident Investigation	n, street, factory, office building, etc.	28f. Location (S	treet and Number or	Rural Route Number, City
Division Isl or Attendir Is after death. at Director: A	Certification:	Suicide Could not be determined (Specify)	i, street, lactory, office barraing, ever	or Town, S		
Hospit Hospit Huner Funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the caus	e(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
F ≥ F S	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (
		my m, m, p	O.C.M.E.		August 13, 200	ມຮ
		30. Name and address of person who completed cause of death (Item 23a)	Street Baltimore MD 24204			
C		20 Registrate Signatural	Street, Baltimore, MD 21201			
S	tate	31. Date filed (Month, Day Year) 2008 32 Registrar's Signature	150000			

State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Month Year **Physician** 13, 12:50 A. ^M August Estelle K. Berkley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Care Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 15, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1914 **Funeral** Days 1 □ M 2 🛣 F 212-01-3519 94 Yrs Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examiliant must be notified at Maryland Baltimore Timonium 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2300 Dulaney Valley Road 21093 USA Funeral Estile Bertley Ang 13 Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Preparer Seafood Restaurant 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bettie Ruhman Reuben James Kenly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Frederick Berkley/Son 30 Elinore Avenue Nottingham, Maryland 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 8/15/08 Baltimore, Maryland Eecharand Cod Rick Facility. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses tto mistre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTHS **Physician** 1SCHMIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. ed by the detached f signed by the detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC KIDNEY DISEASE 24a. Was an autopsy certificate STROKES 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cother (Specify) HOSFICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director: A pletely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64395 AUGUST 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6565 N CHAPLES ST, SUITE 209 BALTIMERE, MD 21204 DANIEUE DOBLEMAN, 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ray P. Benware 2008 August 6 11:32A 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Yrs. 83 Aug. 24, 1924 New York 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Rockville 10g. Citizen of What Country? 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ∐Yes 2 🔀 No Specify: White WW II 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Business Owner Service Industry 18. Mother's Name (First, Middle, Maiden Surname) Lelia Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34986 304 S.W. North Shore Blvd., Port St. Lucie, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 11, Mt. Olivet Cemetery Frederick, Maryland 2008 21. Signature of Funeral Service Licensee

MO1530

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Ave., Rockville, MD 20850-2805

Approximate
Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) Approximate Interval Between Onset and Death Gunshot Wound Head DME Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of Injury 28d. Describe how injury occurred August 6, 2008 | unknown ™ 1 ☐Yes 2 X No self inflicted gunshot wound 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4619 Creek Shore Dr. Rockville, MD 20852 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D00428 August 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira N. Brecher, M.D., DME 2101 Medical Park Drive, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

completely

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 10:15 AM Emma Ann Burke 8 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 5 17 1920 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 88 Director 215**-**10-4023 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3013 New York Ave 21227 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No ģ Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Medie. Once. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles McKeldin Emma Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Burke 3013 New York Ave. Baltimore MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/15/2008 National₂₂ Baltimore, MD Cemetery Standard Ambrose Funeral Home of Lansdowner 21227 21. Signature of Funeial Service Licensee 2719 Hammonds Ferry Rd Lansdowne, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical as 1 IF FEMALE: use yes, outcome pf pregnancy □Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page, 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21**X**No 1 ☐ Yes 1 Ninpatient Medical Certification: To 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertries 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar (Mohth, Day, JG 15

State of Maryland / Department of Health and Mental Hygiene 26304 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day **Physician** 1527 PM Diane P. Brown 2008 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🖫 F Days Hours Yrs Director 218-46-2971 Dec 5, 1947 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Mcical Examinat", ust by rictified at Director 1 XYes 2 No Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 3312 The Alameda 21218 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Friends School Housekeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellwood Brown Marie B. Thomas ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Marie B. Bacon 3312 The Alameda Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Bemoval from State 4 Donation 5 ☐ Other (Speoffy) 08/18/08 Windsor Mill, Md. King Memorial Park ignature of Funery 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEUMONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE DAYS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) SEPSIS iaw requires that the death certificate be executed Exami burial-trans 2 DAYS and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d, Date of delivery 3 Ectopic pregnancy ģ Month Year Day 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autonsy To the Hospital or Attending Physician; The certificate perform 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 AUGUST, 10,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL MARYLAND BALAKRISHNAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Maryland	d / Department of I			711118	26305
			Registrar 1. Decedent's Name (First, Middle, Last) , , , ,	Certificate of		Reg. No.		3. Time of Death
	Physici /Medi		Josey	oh N.	Blue	/	Month Tugus	7 12, 2008	10:50 PM
	Examir	er	4a. Facility Name (If not institution, give		730	Location of Death	/	Ic. County of Death	to an in the
	Funeral		5. Social Security Number 6. Se		ast birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	M 20 F 62	Yrs. World's Days	110013	Jet 21,	19+5 was	hington, D.C
	ryland	_	10a. State 10b. County	. 10c. City	, Town or Location	e ,			10d. Inside City Limits
	the Ma 28a-f s	ecto	10e. Street and Number	Imore	Catons 10f. Zip Code	ville	10- (Citizen of What Cour	1 □ Yes 2 TXÍvo
	h with	al Di	16 Fustiv	in Ave	2,	228	10g. c	US	A
	er deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diest Exeminer must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 □ Yes 2 🕱 No	Specify:		Specify:	Black
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212	filed within Hygiene. other than ent, it	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	ction	Miker CI	enstru	iction
	be filec stal Hyg sd othe event,	Be	17. Father's Name (First, Middle, Last)	21.0		18. Mother's Name (First, Middle, Maide	an Surname)	
Maryland	should be and Mental is marked of aumatic eve	2	19a. Informant's Name/Relationship (Ty	Print) C. C.	19b. Mailing Address (Street	ETU +	Poute Number City	niTh	n Code)
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altimore,	8 6 = 0		20a. Method of Disposition 153 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	ace of Disposition (Name of emetery, crematory or other place	Date Date	e 20c.	Location - City or To	own, State
Ħ	permit. Page Department i Important: if any injury or		4 Donation 5 Other (Specify) 21. Signature uneral Service Licens	1/Y	22. Name and Addre	ss of Facility 7- 6	08 1	indae	Kimi),
å	permi Depa Impo any Ir		Jany M. M.	mel	Gary Pi	march	PH. 1	otto.	MJ21209
E			23a. Part 1. En rythe disease, or compleshock, or eart failure. List only or	cations that caused the death ie cause on each line.	. Do not enter the mode of dying	ng, such as cardiac or r	espiratory errest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Crose (Final disease or condition resulting in death)	Due to (or as e consequ	Cl.				
	Examiner	_	Sequentially list conditions,)					
1	uted I	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequ	ence of):				
8760,≿	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
		dical		1.					
Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was deceder pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal				23d. Date of deliver	ery
о В	at the dear by the att	ysicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of de		- -		Month	Day Year
σ.	signed by	by Ph	Part II. Other significant conditions con	tributing to death but not resul	Iting in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
Records,	w require been sig should by	ted b			· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes	2 万 № 3 □ Prot	bably 4 🗆 Unknown
Rec	has b	Completed					24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
Vita V	rsician: The law s certificate has b lirector, page 2 sl	Be Co	25. Was case referred to medical			26. Place of Death (0	1 ☐ Yes 2 ₺	1 ☐Yes	2 MNo
	Physic this ce al direc	욘	I les Zello		ER/Outpatient 3 DOA Oth	er: 4 Wursing Home	5 Residence	6 ☐Other (Specif	fy)
Ou	nding Phys ith. : After this e funeral dir	tion	27. Manner of Death 1☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury World 1 □	yat 28o k? Yes 2 ∐No	d. Describe how inj	ury occurred	
Division of	or Attenditer death.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, street, factory, office	28f	Location (Street a	and Number or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Deertifying Phys	sician: To the best of my know	vledge, death occurred at the ti	me date and place an	d due to the cause	(s) and manner as	etated
	he Hos in 24 h he Fun pletely	Medical	(Check only 2 Medical Examilione)	ner: On the basis of examinati and manner stated.	ion and/or investigation, in my o	pinion, death occurred	at the time, date a	nd place, and due to	o the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. Licens	e number	29d. D	Date signed (Month,	Day, Year)
	0	ŀ	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	156414	/	8-14-	08
	7		Jocelyn 1	=1- Sayed	MD. MPH 1	6 Fusting	Avenue	Catonsu	ille, MD
	Sta Registra		AUG 1 5 2008	32. Registrar's Signatu	medi				

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

Baltimore, Maryland 21215-0036

and P.O. Box 68760.

Division of Vital Records,

AUGUST 11, 2008 7:13 A M **JAMES** LEWIS **BOWERSOX** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON 5. Social Security Number Sex M 2□ F 7. Age (In yrs. last birthday) 81 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 3/9/1927 Months Days Hours 217-24-8818 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, If w Madical Exempter trust be notified at anones. 10a. State 10c. City. Town or Location 10d. Inside City Limits BALTIMORE OWINGS MILLS 1 □Yes 2XINo **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 1 CORNBURY COURT 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married Married 1 □Yes X□No WHITE Specify: þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING MANAGER WJZ - TV17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GEORGE BOWERSOX** ANNA COOPER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEILA BOWERSOX / WIFE CORNBURY COURT OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM: 8/14/2008 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PLOSTATE CANCER **Physician** UZARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 1 Yes 2 No 6 Other (Specify) HOSPICE Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) DOBERMAN CHARLES ST, SUITE 209 BALTMONE MD 21264 MD 6545 31. Date filed (Month, Day, Year) AUG 15 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12, 2008 Month Augi 10:15PM **Physician** Alexander Drummond Cockey, Jr. 72+ 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ø Examiner Point If Under 24 Hrs. VA Maryland Nealth Care System

5. Social Security Number 6. Sex. 7. Age (In yis. last birthda C 8. Date of Birth (Month, Day, Year) Sept. 02, 1922 9. Birthplace (State or Foreign **Funeral** Months Hours Baltimore, MD. 85 20chey, 219-18-0221 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event inserts at the retitled and once. 1 □ Yes 24 No Director Maryland Cecil County Perry Point 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21902 Perry Point VA. Hospital Funeral norme Known to Physician: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: W • W • II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2¥Q2No Specify. 2 Specify: 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Photographer Photography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Drummond Cockey, Sr. Nellie Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 224 W. Timonium Road Timonium, Maryland Mr. John Logan Cockey (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 2008 1 Burial 2 Cremation 3 Removal from State 17, Druid Ridge Cemetery Park Heights, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peacerul Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Parri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bowel **Physician** unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Jua to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditio</mark>ns contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown anounc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No r this certifice ral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: ,
d in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

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Thomas Biondo, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 Julie January Land Health Care System, Perry Point, MO 21902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** claude 5:05 PM Comegna August 2008 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Bayview Johns Hopkins Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 12 M 2□ F 213-32-5261 Director Dec. 8,1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 21XNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3420 Dunran Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2₺ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Lithographer Printing Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Comegna Margaret Diddlemeyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marjorie Comegna (Wife) 3420 Dunran Road Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of comejery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5/□ Other (Specify) Lawn Cemetery Oak 8/15/2008 Baltimore, Maryland 21. Si ature neral Service icens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonio Week disease or condition /Medical resulting in death) Due to (or as a consequence of) Examine Pulmonary Disease Obstructive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and -tran Due to (or as a consequence of) physician Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of page 2 s certificate has autopsy death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 No Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one -To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: or Attending (Month, Day Year) 1 Natural 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Plaistrar's Signature

DHMH 17 Rev 1/2001

State Registrar Eastern

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Avenue

29c. License number

RES - 000

Baltimore

29d. Date signed (Month, Day, Year)

12.

21224

2008

Angust

	1- State of Mai	ryland / Department of Health a Certificate of Death	nd Mental Hygiene Reg. No. 2 0	08 26309
Physician /Medical	Decedent's Name (First, Middle, Last) Donald Q.	Cornish	2. Date of Death Month AUG 13 Th &	Year DOS 10: 27 A M
Examiner	4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITAL	4b. City, Town, or Location of	Death 4c. County	of Death
Funeral Director	H-M 2□ E	3 Yrs. Months Days Hours	Min. (Month, Day, Year)	9. Birthplace (State or Foreign Country) Baltimore.Md.
Maryland -f show led at	10a. State 10b. County Md. Harford	10c. City, Town or Location Abingdon		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show rmust be notified at meral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of N	·
	103 Waldon Road. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 MDivorced 15. Pacadatic Education	lf Yes, specify Cuban, Mexican 1 □ Yes 2X No <i>Specify:</i>	Specify	ce - American Indian, ck, White, etc. y: Black
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours af beartment of Health and Mental Hygiene. mportant: If them 27 is marked other than "natural"; or nny injury or other traumatic event, the Medical Exami nnee. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Fireman	of working	usiness/Industry more_City
aryland should be file should be file and Mental Hy marked other umatic event.	17. Father's Name (First, Middle, Last) Rowland Cornish		s Name (First, Middle, Maiden Surnan rginia Cornish	ne)
re, Maryla s 1 and 2 should Health and Mer them 27 is marke other traumatic	19a. Informant's Name/Relationship (Type. Print) Eric Cornish Son	19b. Mailing Address (Street and Number 10819 Marthon Da		
MOTE, Pages 1 a ent of He nt: If Item ry or othe	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location -	City or Town, State
Baltimore, Maper and 2 permit. Pages 1 and 2 Department of Health a Important: If them 27 is any Injury or other transones.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Estep Bros.FSP Lace, Baltimore,	Α.
Physician /Medical	resulting in death:	he death. Do not enter the mode of dying, such as one of the such as of the such as one o	cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
68760, ifficate be executed g physician and as the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	COTE RENAL FAILUR CONSEQUENCE OF: AGE CHRONIC OBSTRU consequence of):		
Box (death certification of for use an ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pl 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3 Ectopic pregnancy		te of delivery onth Day Year
ecords, P. law requires that the as been signed by 2 should be detailed by Philippleted Philippleted Phi	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.		tribute to the cause of death?
The law rate has be page 2 sh	25. Was case referred to medical		autopsy performed? 1∐ Yes 2 ☑ No	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
on or Vita ding Physician: After this certific funeral director,	examiner? 1 ☐ Yes 2 (A) No Hospital: 1 (A) Inpatient	2 ER/Outpatient 3 DOA Other: 4 Nur	of Death <i>(Check only one)</i> sing Home 5 ☐ Residence 6 ☐Oth	ner (Specify)
Division c tral or Attending P rs after death. ral Director: After t led in by the funera Certification:	27. Manner of Death 1 ★ Natural 5 Pending (Month, Day 1) 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	M 1 Yes 2 N		
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	4 Homicide determined 20e. Place of injury building, etc.		28f. Location (Street and Numb City or Town, State)	·
o the Hospi ithin 24 hou of the Funel ompletely fil	one) 2 Medical Examiner: On the basis of e and manner state		I place, and due to the cause(s) and ma h occurred at the time, date and place,	anner as stated. and due to the cause(s)
To To Oor	29b. Signature and title of certifier Malliva. A	29c. License number	7 AUG 13	d (Month, Day, Year) IF えのOS
	30. Name and address of person who completed cause of dea MALLIKA · ANGITIPALLI , St.	th (Item 23a) (Type, Print) ACNES HOSPITAL, 900	S. CATON AVENUE	BALTIMORE MD-21229
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar	s,Signature		•

	•	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of He tificate of D	ealth and M Death	lental Hy	giene Reg. No.	308	26310
Physicia /Medic		Decedent's Name (First, Middle, Last) AARON		С	ANTER		2. Date of Dea Month AUGUS		Year 2008	3. Time of Death 10:10P M
Examine	er	4a. Facility Name (If not institution, give st. PINE HILL ASSISTED 5. Social Security Number 6. Sex		ast birthday)	4b. City, Town, or L FULTO			4c. Count	y of Death	RD
Director		578-03-6872 1XIII	^{M 2□ F} 96	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 09/09	71911	9. Birthpla Countr	^{y)} MD
Marylanc -f show	ţ	10a. State 10b. County MD HOWARD		, Town or Lo	cation				100	d. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number		JE TUN	10f. Zip Code	2702		10g. Citizen of		•
	by Funeral	8455 MURPHY ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.\$ Armed Forces? 1 □Yes 2 □NO If Yes, Give		Vas Decedent of His Yes, specify Cuban	0723 spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Speci	USA ace - American ack, White, etc	n Indian,
hin 72 hour e. medical E.	Completed t	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Year or Dates: tion complete d) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du OO NOT use retired)	tion uring most of worki	ing	16b. Kind of E	Business/Indu	stry
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e, Ivid 1 and 2 s Health ar em 27 ls ther trau		MARTI KURLAND /	NIECE	2213	MILLRIDGE	E ROAD, (OWINGS N	ILLS,	MD 21	117
permit. Pages: Department of I Important: if ite any injury or of		20a. Method of Disposition 1	moval from State	KUREAI	sition (Name of PAPA or Albert Place ND CONG.	08/13	3/2008	BALTII	MORE,	
permit Depar Impor any in		21. Signature of uneral pervice Licenses	Man		Name and Address R900 REIS	3(OL LEVII ROAD -			
Physician // /Medical		23a Part 1, Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ADVANC	0	er the mode of dying DE MERTI		or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner	_	Sequentially list conditions, b.	Due to (or as a consequ							
secuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
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Physicia this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	Othor	26. Place of Death 4 □ Nursing Ho			ther (Specify)	ASSISTED
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specify	28b. Time of Injury me, farm, stre	1	at es 2 □No	28d. Describe It	now injury occu Street and Num	rred	LIVING
Hospital Hospital Hours a Funeral C		(Check only 2 Medical Examine	cian: To the best of my known: On the basis of examinat	wledge, death	occurred at the time	e, date and place, inion, death occur	and due to the	cause(s) and n	nanner as sta	ated.
To the within 2 To the comple	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date sign	ed (Month, D	ay, Year)
	-	30. Name and address of person who com	pleted cause of death (Item	23a) (Type, F		1860		8/1	2/20	2/544
State		JONATHAN FILL	4 MD /	5700 ure	CHARTER	Daire #	-200 C	ocvasi.	A Mo	21044
Registra	r	31. Date filed (Month, Day, Year) AUG 15 2006	of the see the	E ON	32					

			1 - For State Registrar	State of Marylan		artment of F rtificate of a		-	giene Reg. No. 201	08	26311
ì	Physici		Decedent's Name (First, Middle, Last) JAMES	MARTIN		CHERR	 ?Y	2. Date of De Month	ath Day K Z	ear 3	3. Time of Death
	/Medid Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o			4c. County of		2.00
mer l'			NORTHWEST HOSPITA		F	RANDALLS If Under 1 Year		10.5-1.45	BALTIM		(0)
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,	vith the	Director	10e. Street and Number			10f. Zip Code	01000		10g. Citizen of What	,	?
	eath v	Funeral	8202 STREAMWOOD I	12 Was Decedent Ever in 115	S 13 \	Was Decedent of H	21208	Specify Yes or No	- 14 Bace -	USÁ	Indian
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altim	permit. Pages Department of Important; If it any injury or o		Donation 5 ☐ Other (Specify) 2. Sign ☐ of Funeral Servic License	BE BE		LOH CONG	1 '	14/2008	BALTIMO	-	
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		ă ș	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death e cause on each line.	n bo not ente	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Ap Int Or	pproximate terval Between nset and Death
Mary States	Physician /Medical		disease or condition resulting in death)	Due o (or as consegu	tery Jence	tallure	3				
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XOD	h certiif ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		10.			23d. Date of	of delivery	
	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnanc Other <i>(specify)</i>	у		Month	n Da	ay Year
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DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre			28f. Location (S City or Tov	Street and Number vn, State)	or Rural Ro	oute Number,
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	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (/		
	100		Newakhere			1+4	F5934		August 1	2:14 2	2008
	5,		30. Name and address of person who cor	npleted cause of death (Item	123a) (Type, F 1 47 /V	street	Neisters	trun K	D		
L	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 5 2008	32. Registrar's Signat	ture	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 8 26312 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 15, 2008 Eleanor Derrick Lois 6:10am [™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 9, 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ▼F Country)
MD Months Days Hours 212-24-7761 80 1927 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1308A Old Manchester Road 21157 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmon M. Day, Sr. Beulah A. Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah L. Watson (Executor) 1308A 01d Manchester Road Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 8/16/2008 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗀 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 22No 1□ Yes 2XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2**X**(No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the Hospital

within 24 hours after death To the Funeral Director:

29b. Signature and title of certifier sunsulipa MD ANSURIYE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0051705

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

08-15-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 349 malcolm

DR.

Mestminster, mo 21157.

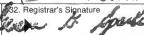
State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) AUG 1 5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		C	ertificate d	of Death	R	leg. No.	008	20	31.
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	th Day	Year	3. Time of	
	/Medic		Sophie Dre	vayer				August	12	2008	5:58	PM
1	Examin	er	4a. Facility Name (If not institution, g	,			n, or Location of Dea	ath		nty of Death	_	
ard.			STELLA MARIS HOS 5. Social Security Number 6.		land blodbal		WSON ar If Under 24 Hr	'S Date of Digit		_TIMOR		u Causina
	uneral rector		216-14-3122	1 M 2	yrs. last birthd Yrs	Months Da			, Year) , 1922	Mar	place (State on htry) y land	r Foreign
and	M T		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location				1	0d. Inside Cit	ty Limits
Maryi	fsho	ò	Maryland Harford	t	Jopp	а					1 ☐ Yes	2 X No
the	28a	rec	10e. Street and Number			10f. Zip Cod	e		I0g. Citizen o	of What Coun	ntry?	
h with	23a or	a D	408 Foster Knol	l Drive			21085		USA			
2 should be filed within 72 hours after death with the Maryland and Mental Hydiene.	item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I's. Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2□ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes ※X No If Yes, Give	in U.S.	3. Was Decedent of If Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)	14. R B	lace - Americ lack, White, o		
hours	itural"	q pa	3 Novel 4 □ Divorced	Year or Dates:	16a. De	ecedent's Usual Oc	cupation	- 1		Business/Inc	dustry	
. 2 ie 4	n "na Medic	Completed	15. Decedent's I (Specify only highest g		(G	ive kind of work do e. DO NOT use re	ne during most of wi tired)	orking			,	
d with giene	ar tha	ĕ	5th grade	College (1-4or 5+)	(Cashier			Retai	il Foo	d Indu	stry
H H	othe vent,	Bec	17. Father's Name (First, Middle, Las	it)			18. Mother's Na	ame (First, Middle,	Maiden Surn	ame)		
uld b Ments	irked itic e	10 E	Stanley Ciekot				Joseph	ine Bende	r			
sho and l	ls ma		19a. Informant's Name/Relationship		Ī		eet and Number or I				Code)	
and 2 should ealth and Mer	n 27 her tra		Ethel Biensach	· • · · ·		0 Ebenez		altimore,				
mit. Pages 1	Important: If item 27 Is any injury or other trau once.		20a. Method of Disposition ★★Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐ Hemova: from State		sposition (Name of crematory or other od Cemete		Date 6 * 2008	20c. Locatio	•		
permit. Departr	Importa any inju once.		21. Signature of Funeral Service Lice	-			dress of Facility_	Home Baltimore				1,3011
			23a. Part 1. Enter the disease, or co	mplications that caused the	death. Do not						Approximate	e
	sician edical	8 8	shock, or heart fallure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Metas		sreast Co	incer				Interval Bet Onset and I USCAL	Death
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S exe	an ar rial-tr		resulting in death) Last	Due to (or as a cor	nsequence of):	-						
oo / ou,	attending physician and for use as the burial-transit	Medical		d								
artifice	ing pl	Med	if FEMALE:									
S the	ttendi or use	-	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregn	ancy			Date of delive Month		Year
e de	the a	hysician	1 ☐ Yes 2 M No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death	5 ☐ Other (specify	<i>'</i>)			NIONIT	Duy	TO CIT
hat t	ed by detac	Δ.	Part II. Other significant conditions	contributing to death but no	t resultina in th	e underlying cause	given in Part I.	23e. Did to	bacco use co	ontribute to the	he cause of d	death?
w requires t	ector: After this certificate has been signed by the by the funeral director, page 2 should be detached	d by	·	Ü		, ,		1 □ Y	es 2 □ No	3 □ Prot	pably 4 🔼	Unknown
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he fa	e has	m d						- autop: perfor	sy med?	prior to co death?	mpletion of c	ause of
cian: T	ifficat or, pa	o C	25. Was case referred to medical				OC Plans of D		2 No	1 🗆 Yes	2 □ No	
Sicia	s cert	<u> </u>	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 □ EB/Outps	tient 3 DOA	0.11	eath (Check only or Home 5 \subseteq Resid		Other (Cii	6.1	
2 g	er this	٦.	27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. I	njury at	28d. Describe h			<i>y</i>)	
ding.	: Afte	ţi	1 Accident 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Yea	ar) Inju	*	Vork? I∐Yes 2∐No					
Atte Atte	ector by th	ifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm,	street, factory, offi	СӨ	28f. Location (S		mber or Rura	al Route Num	nber,
tal or	al Dir	Certification:	4 Homicide	Dunung, etc. (5)	poony)			City or Tow	n, siate)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Dir completely filled in	edical		Physician: To the best of my aminer: On the basis of exa and manner stated.								;)
To th within	To th	Me	29b. Signature and title of certifier			29c. Lic	ense number	- 1	29d. Date sig	ned (Month,	Day, Year)	
	1		Domuie Cox	on MD		104	1797		8/131	108		
6	7		30. Name and address of person wh		(Item 23a) (Ty	Drint)	*					
9			Bunnie Cohen	40 23001	Delane	1 Valley	Rel Til	nonivm-n	10210	093		
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar's S	Signature	100						

Registrar

08-06132 Micha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Dorman			ate of Ma	aryland	/ Departi	ment of	Health	and	Mental	Hygier			2008	263
	Rec	or State istrar Decedent's Name (First, Middl	a Last)		Certif	icate of	Jean				Reg. Ne of Death		3. Time of	Death
Physician/ Medical Examine	r		Mid	chae1		orman	. City, Tow	n orlo	cation of D		ust 9, 20	08 4c. County of I	2330 h	ırs
4 -	4a.	Facility Name (if not institution 1913 Neville Road	n, give street	and number	er)		Dundalk					Baltimore	=	
Funeral	5.	Social Security Number	6. Sex	7. /	Age (In yrs. last	birthday)	if Under 1	Year Days	If Under 2	Min		1	Birthplace (Sta Country) MI	
Director		218-64-4791	1XM 2	F	53	Yrs.	Montins	Days	Hours	0	ct. 26	,1954		
	_	ual Residence of Decedent a. State 10b. County			10c. City. To	own or Location	on							e City Limits
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Baltimore, MD 21215-0036 2.0.8 2.0		. Marital Status		Vas Deced	ent Ever in U.S. es?	13. Wa	Decedent es, specify	of Hisp Cuban,	anic Origin Mexican, P	? (Specify Puerto Rican	Yes or No- ı, etc.)	White,	American Indian, etc.	Diack,
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15-0 filed w of others		7. Father's Name (First, Middl Leo John Do		Sr.				- 1	He	elen M	Marilla	a Warfi	eld	
212. Menta marke	1 Be	9a. Informant's Name/Relation	nship (Type, F	Print)		19b. Mailin	g Address	(Street	t and Numb	er or Rural	Route Numb	er, City or Town Maryla	n, State, Zip Code nd 2122	*) 2.2
MD 12 sho th and th and 1.27 is umati	- 1	Jennifer Kalt	reider	(Day	ughter)	191. lace of Dispos				Da	te	20c. Location -	City or Town, Sta	ate
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876(ifficate ng phy as the t	W/W	IF FEMALE: 23b. Was decedent pregnant past 12 months?		Live b		2	etal death	3	Ectopi	c pregnancy	/	Month	Day	Year
Box 68760 e death certificate be the attending playsi	Physician/Me	1 Yes 2 No 9	Unknown g	' -	ant at time of de	eath 5	Other (Spe	cify)						
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Division of Vital Records, the law requires and referent. The law requires and referent. After this certificate has been signed in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Completed										1 🗸 Yes		1 🗸 Yes	2 No
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f Vit Physic or this cral dire	၉	1 ✓ Yes 2 No 27. Manner of Death		28a. Date	Inpatient 2	28b. Time			jury at Wor			how injury occu	urred	
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risio r Atter er dea irector n by th	ficat	2 Accident 3 Suicide 6 X	Investigation Could not be	28e. Pla	ce of Injury - At			y, office	e building, e		or Town.	State)	mber or Rural Rou	
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director. 7 completely filled in by the fi		29a. Certifier 1 Certifyi (Check only one) Medica	ng Physician Examiner: C	: To the be in the basis	est of my knowle	edge, death of and/or invest	curred at thigation, in r	ne time, ny opini	date and p ion, death o	occurred at	the time, date	e and place, an	d due to the caus	e(s)
To th Withii To th	Medical	29b. Signature and title of c	aı	nd manner	stated.				ense numbe			29d. Date si	igned (Month, Da	ıy, Year)
*	-	Do NUC	Dink	IMD				0.0	C.M.E.			August 1	12, 2008	
		30. Name and address of p		mpleted ca	use of death (Ite	em 23a)	444.5	- 01	of Deli-	more Mr	21201			
		Donna M. Vincent	ti, MD A	ssistant	Medical Exa	aminer	111 Peni	Stre	et, Baitir	more, MD	Z 1ZU1			
Regi	State	n I I C	Year) 1 5 200		egistrar's Signa	B A	medi	·						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06076 2008 25315 State of Maryland / Department of Health and Mental Hygiene Peyton Bernard Drayer 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Peyton Beanard Drayer Physician/ 0009 hrs Peyton Bernard Drayer August 9, 2008 al Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel northbound Route 3/ south of Waugh Chapel Road Gambrills 9. Birthplace (State or IEXAS 7. Age (In yrs. last birthday) 43 3. Date of Birth (MM/3D/YYYY) June 22, 1965 If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Min 530-88-7657 Director Country) Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any Yes 2 XNo MD Severn 23a or 28a-f show notified at once Anne Arundel death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 21144 10e. Street and Number 8349 Flintlock 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Black 9 If Yes, Give Year Yes 2 No specify: Specify Divorced hours after ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical be filed within 72 Cardio Vascular Tech permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' injury or other traumatic event, the Medical 21215-0036 +2 Comp 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Willie Bea Drayer Susie Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8349 Flintlock CT. Severn Maryland, 21144 19a. Informant's Name/Relationship (Type, Print) B Stella Drayer/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place)
Crownsville Cem Crownsville, MD. Burlal 2 Cremation 3 Removal from State 8/18/2008 Donation 5 Other Specify AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring, Arbutus, Maryland 21227 21. Signature of Funeral Service Licensee amis Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last NA and #1,perME g882 8/19/08 TT Physician/Medical UNPENDED ending physician use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) law requires that the death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown pleted Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Com ✓ Yes 2 1 1 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Motorcycle driver lost control Certification Aug 9, 2008 0003 hrs Natural Yes 2 V No Pending / Director: death 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Northbound Route 3/ South of Waugh Chap, Gambrills, determined (Specify) Major Road / Highway To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year DO)

30. Name and address of person who completed cause of death (Item 23a)

amonte

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 9, 2008

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 10SSAM Diggs 4090 ST Valiant /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NorthWest Hospital Randallstown
If Under 1 Year | If Under 24 Hrs. | 8. [Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2√2 F Director 218-80-4706 Nov.8,1962 45 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evaniner must be notified at 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. by Funeral 5880 Belair Rd. filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12thYouth Works and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Sallie Hooker Paul Diggs Jr. ၉ Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is 5880 Belair Rd. Baltimore, MD 21206 Tamika Murray/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. Number 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH AUG. 19, 2008 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral S B. SCRUGGS FUNERAL HOME PRESTON ST. BALTIMORE, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END STAGE A LOS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 ☐ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification prompletely filled in by the funeral director, prompletely filled in by the funeral director, promple 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be STASONS Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1445931 August 10 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTENSTOWN MO 25 MAIN STREET borah PIETCE UG 1 5 32. Registrar's Signature State Di Sporte Registrar

08-06079	
Roshida Elbey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26317

		1- For State Reg. No. Reg. No.	JI
Physici Vadical Exam	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Mooth Day Vect 3. Time of Death	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 607 N. Pulaski Street Baltimore City	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or For	reign
Director	_	213-84-1790 1 M 2XF 42 Yrs. Months Days Hours Min. Nov. 17, 1965 Maryland	1
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	
ryland a-f shor	ctor	1 Dyes 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	No
hours after death with the Maryland inatural", or items 23a or 28a-f sho Examiner must be notified at once.	Funeral Director	607 N. Pulaski St. 21217 USA	
leath wit r items 2	unera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
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2 3	leted	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-0036 led within 72 hot Hygiene. other than "nat	Completed	17. Father's Name (First, Middle, Last) NUTSING ASSISTANT MEAICAL 18. Mother's Name (First, Middle, Maiden Surname)	_
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be (Ronell Nance Sadie Lee Ragsdale	
AD 2 shc 1 and 27 is mati	1	Ms. Brenda Gaither 2111 Koko Lane Balto. Md. 21216	
TOTE, Nages 1 and nt of Health t: If item other traw		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State	11
Baltimore permit. Pages 1 a Department of He Important: If it injury or other t		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Facility 12. Name and Address of Facility	a,
Physician		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inte	
′Medical ≟xaminer	ì	Immediate Cause (Final disease a. Narcotic (Morphine) intoxication and cocaine use Death	and
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
recuted 1 and - transit		events resulting in death) Last Due to (or as a consequence of):	
ial e	Medical	X UNPENDED = AMENDED 23a, 27, 28a-f, perME, g882 8/18/08 TT	
ox 68760, eath certificate but attending physic for use as the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1	
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
₹ ₹ ₹ 5	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown	
of Vital Records, P.C. ng Physician: The law requires that ther this certificate has been signed I meral director, page 2 should be deta	Completed	24a. Was an 24b. Were autopsy findings avail autopsy prior to completion of cause	
tal Recorian: The la		performed? death? 1	,
Vital hysician this cert	To Be	25. Was case referred to medical examiner? 1 Ves 2 No	
Division of Vital pital or Attending Physician: ours after death. reral Director: After this certif		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural Pending Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred unk	
Division tall or Attendiners after death. al Director: A led in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town State) 6 0.7 N Pulaski St	City
Di Hospital 24 hours a Funeral B		29a. Certifier	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 9, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	
	tate	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (April Day Year) 2008 3. Registrar's Signature	
Regis	trar	HOGIT 3 2000 Program A Transport	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Ford OM richard 08 2008 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Specialt Bettimore Baltimore Cit University 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1X M 2 ☐ F Months 25, Director 216-94-8117 43 DEC. 1964 Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e r than "natural", or items 23a 4702 FREDERICK AVE. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 No Specify δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatte events. 12TH MAINTENANCE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RICHARD F. FORD, SR. INETTA SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INETTA FORD/DAUGHTER 2019 EAGLE ST., BALTIMORE, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c.Location City of Town State 5500 O DONNELL ST 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TRINITY 08/15/2008 BALTIMORE, MD 21224 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALT

23a. Part1. Enter the discarde, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail for List only one cause leach line. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bleeding /Medical Due to (or as a consequence of): Examiner Iremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last - Stage Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Dependen Plespiration 2 No 25. Was case referred to medic examiner? funeral director, 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural in 24 hours area.
the Funeral Director: Affinoletely filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

death certificate be execu Box 68760, Records, Vital o Hospital or Attending

Maryland 21215-0036

Baltimore,

State Registrar

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the the

DHMH 17 Rev 1/2001

(Check only one)

31. Date filed (Month,

29b. Signature and title of certified

G 1 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

(5VL

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061882

South Charles Stree

29d. Date signed (Month, Day, Year)

8-08-2008

2,230

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 9:00 P M Mabel Ford July 27,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Nursing Home Prince George's Lanham 1914 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 2 🔼 F 579-05-6078 93 September 7, Director Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street-and Number 8200 Good Luck Road 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Black If Yes. Give Specify: Completed by 3 ₩idowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tenth Private None Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Lucinda Woodland ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3746 Dolfeid Ave Baltimore MD 21215 Frances G. Stevens 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition August 2, 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury Maryland National 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home Inc 389 Rhode Island avenue NW Wash DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZHEIMER'S DEMENTIA **Physician** 1-ca RS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) P.O. 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1∐Yes 2 🙀 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No

Year

29d. Date signed (Month, Day, Year)

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

FLORE 31. Date filed (Month, Day, AUG Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 4203QUEENSAURGRA HYATTSVILLE MX20781 32. Pojistrar's Signature

1 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DHMH 17 Rev 1/2001

			For State	State of M	Naryland / Dep	oartment of F ertificate of			200	8 26320
			Registrar 1. Decedent's Name (First, Middle	, Last)		crimeate or	Dealli	2. Date of Death		3. Time of Death
	Physicia /Medic		Nettie	G.	. F1	cance		August	Day Year 12, 2008	4:45 p M
and is	Examin		4a. Facility Name (If not institution,	give street and number			r Location of Dea		4c. County of Dea	
g. J.			18260 Pretty Bo	*		Park			Baltime	
	Funeral			6. Sex 7. A 1 ☐ M 2 🖾 F	age (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) C	thplace (State or Foreign ountry)
	Director		219-12-5311 Usual Residence of Decedent		87 Yrs.		<u> </u>	Nov. 7,	1920 Vi	rginia
	ylanc how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-f s	To Be Completed by Funeral Director	MD Bal	timore	Parl	cton				1 □Yes 2X No
	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Co	ountry?
			18260 Pretty B	oy Dam Road			21120	Cassifu Vac or No	USA 14. Race - Am	·
	ter de		 Marital Status Never Married 2 Marrie 	Armed Forces	? ?	 Was Decedent of I If Yes, specify Cub 	an, Mexican, Pue	rto Rican, etc.)	Black, Whit	
99	urs al		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 □Yes 2 🙀 No	Specify:		Specify:	√hite
2-0	72 ho natur fical		15. Decedent' (Specify only highes	s Education	16a. De	cedent's Usual Occup	oation during most of we	orkina 1	16b. Kind of Business	/Industry
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22	iled w Hygie I her ti nt, In		17. Father's Name (First, Middle, L	ast)	F	Housewife	18 Mother's Na	ame (First, Middle, M	Own Hor	ne
Maryland 21215-0036	ould be f Mental arked o atic eve		School		lall			trude Lu	· ·	
ary	should and Mer s marke umatic		19a. Informant's Name/Relationsh			iling Address (Street	L		City or Town, State,	Zip Code)
ž			Larry J. France	Son	1845	Deer Par	k Road	Finksburg	, MD 2104	48
altimore,	ges 1 and it of Heal if item 2 or other		20a. Method of Disposition	2	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date 2	20c. Location - City or	Town, State
Ĕ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Donation 5 ☐ Other (Sp		8	en Mem. Pa	i	6/08	Finksburg	, Maryland
Balt			21. Signature of Funeral Service L	licensee	·	22. Name and Addre	1		terstown I	
	Physician /Medical Examiner	dical Examiner	23° Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval							
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الحر			resulting in death)		s a consequence of):	To the state of	1.			zgens
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687	tificat ng phy as the	ledi								
Вох	requires that the death certificate seen signed by the attending phys hould be detached for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		B ☐ Ectopic pregnanc	ev.		23d. Date of de	
O. E.	e dea the at ied fo	sici	1 ☐ Yes 2. No	1 Yes 2 No 4 Pregnant at time of death 5					Month Day Year	
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Records,		Completed	12000	n covenar	The state of the s	Tour -		24a. Was an		
ě	has pe 2	mp	almer	ma				- autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of
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		To Be	examiner? 1 ☐ Yes 2 ► No	Hospital:	tient 2 ER/Outpat	ient 3 DOA Oth	or:		nce 6 ☐ Other (Sp.	ecify)
	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In				28d. Describe ho		
<u>S</u>	Attending or death. ector: After by the fune	catic	2 ☐ Accident investiga	ation		M 1 □	lYes 2 □ No			
Division	To the hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In building, e	njury - At home, farm, s etc. (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	lural Route Number,
_	spital ours a neral I		29a. Certifier 1Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.							
	Within To the comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (Mon	th, Day, Year)
			HEA	mo		D	40371		3/13/08	
	5		30. Name and address of person				- C. W			
			Dr Harry Kop 31. Date filed (Month, Day, Year)	20 00 000	cust count	IND BAND	mone, mo	3 21208		
	Sta Registra		AUG 1 5	2008	trar's Signature	20464				
			1100	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🖇 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician BRENDA 18:18PM FRYE August 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 212-18-5862 Min. 1 □ M 2 F Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, I'm Invidical Event in at 1 uss the rottlest at Yes 2□No Director MiT BATIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8036 U.51A 2/22 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify AAK 3 Widowed 4 ☐ Divorced Ye ar or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Worked Never NONCO Non 9RAd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ·BA KINE miD 2150 Timore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MICARME! CEM BAITO, MI Hugast Blook 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Disseminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed DSIS and Due to (or s a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 2 🗆 No 1 🗆 Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

29b. Signature and fittle of certifier

31. Date filed (Month, Day, Year)

AUG 1 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

ACBOR-ENOH MOIPHD, 4940 EASTERN AVENUE, BALTIMORE MARYLAND 21224

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner Funeral Director**

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

SEASONS HOSPICE @ NORTHWEST HOSPITAL

6. Sex

LOTTIE

5. Social Security Number

or Attending Physician: The law requires that the death certificate be executed and Box 68760 attending physician P.O. Division of Vital Records,

1 M 2 F Days 0371071913 **AUSTRIA** 215-01-1858 95 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturar", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 □ No **Funeral Director** BALTIMORE MD N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7001 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married WHITE Maryland 21215-0036 1 □Yes 2 No Completed by If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced or other traumatic event, the Wadical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ATTORNEY AT LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRIEDLER SARAH **AUSFRESSER** SIGMUND ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 534 LAKEVIEW CIR., SEVERNA PARK, MD SANDRA KEMICK / DAUGHTER Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ABurial 2 Cremation 3 Removal from State SHAAREI ZION CONG. 08/14/2008 ROSEDALE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumon /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29b. Signature and title cause of death (Item 23a) (Type, Print) 2 MAIN 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

RANDALLSTOWN

Min.

Hours

FRIEDLER

Months

7. Age (In yrs. last birthday)

2. Date of Death

8. Date of Birth

4c. County of Death

BALTIMORE

9. Birthplace (State or Foreign

Country)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26323

		1- For State Certificate of Death Reg. No.							
Physici C"cal Exami		1. Decedent's Name (First, Middle,Last) 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day August 8, 2008 2. Date of Death Month Day August 8, 2008	e of Death 38 hrs						
)		4a. Facility Name (if not institution, give street and number) Washington County Hospital 4b. City, Town, or Location of Death Hagerstown Washington Washington							
Funeral Director		5. Social Security Number 1 M 2 F 33 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace Foreign Country)	(State or						
ıny		Usual Residence of Decedent	nside City Limits						
and F show a	Director		Yes 2 L No						
vith the Maryland s 23a or 28a-f show any s notified at once		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 1085 U.S.A							
r death v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Ind White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 No specify: 17. Specify:	lian, Black,						
ours after a stratural"	ed by	or Dates:	icz						
036 ithin 72 h ne. r than "r fedical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Food Servers	vice						
215-0036 oe filed within 7 tal Hygiene. ked other than int, the Medica	Be Col								
nore, MD 21215-0036 gges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. I filem 27 is marked other than "natural", other traumatic event, the Medical Examiner	ToE		ode)						
S I S		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, crematory or other place)							
Baltimo permit. Page Department o Important: injury or otl		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugno C. Green Frequency (Constitution of Constitution of Constit	Services						
- Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appr	roximate Interval ween Onset and						
∡xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic intoxication Due to (or as a consequence of):	Death						
	er	Sequentially list conditions, b							
, } - =	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
fred, frate be executed g physician and stree is the burial - transit									
760, ficate be g physici	/Medical	X UNPENDED AMESCEP 27, 28a-f, perME, g884 10/2/08 TT IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 25b. Was decedent pregnant pr	Veer						
	Physiciar		Year						
P.O. Is that the gned by the detached	by	1 Yes 2 No 3 Probably							
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate about 124 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as to	Completed	24a. Was an autopsy prior to complet death?	tion of cause of						
al Re an: The ertificate tor, pag	Be Co	25. Was case referred to medical 26.Place of Death (Check only one)	2 No						
F Vita Physici or this co	To B	D 1 V Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other:							
on of anding Phath. After the funeral	tion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred							
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce								
P. W. F. S.		OCHE	ay, Year)						
		Theodore M. King JR, ms							
\mathbb{Q}		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
S: Regis	tate	810' 1 '5 /1010 1 #7# d to - // // // // //							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06138 State of Maryland / Department of Health and Mental Hygiene Cathy Ann Garner Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day August 11, 2008 Physician/ 1325 hrs **Medical Examiner** Cathy Ann Garner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randalistown 3701 Julian Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours Country) M Director 8-2-1963 1 M 2 XF 45 214-84-9748 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Randallstown M) Baltimore items 23a or 28a-f show ust be notified at once. imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene.
The file of the marked other than "natural", or items 23a or 28a-f sho or other trannante event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number 3701 Julian Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. Armed Forces? Married 1 X Never Married Specifican-American Yes Yes 2 X No specify: If Yes, Give Yea 1 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) by 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Md. Management Co. Bookkeeper 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia A. Garner Be Francis M. Garner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3701 Julian Court, Randallstown, MD <u>21133</u> Baltimore, MD George E. Thomas/ Fiance 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8-18-08 Woodlawn, MD King Memorial Park Donation 5 Other Specify: 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto..Co. ture of Funeral Service Licenses 9200 LibertyRoad, Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Retween Onset and **Physician** failure. List only one cause on each line Death /Medical Dilated cardiomyopathy Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED 23a,27,perME, g883 9/16/08 TT and Physician/Medical UNPENDED the attending physician led for use as the burial -23d Date of delivery Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth signed by the attending be detached for use as past 12 months' Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a, Was an prior to completion of cause of autopsy performed' certificate has 2 No 1 🗸 Yes ✔ Yes 2 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical fineral director, Division of Vital Be Residence 6 V Other: Scene Other₄ Nursing Home 5 examiner? Hospital: FR/Outpatient 3 Inpatient 2 this 1 ✓ Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 12, 2008 O.C.M.E. RUL 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) 5 Registrar

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			1 _ State	te of Marylan		artment of F		d Mental H	ygiene	2008	26325
п			Registrar 1. Decedent's Name (First, Middle, Last)	,	Cei	lilicate of t	Dealli	2. Date of D		2000	3. Time of Death
Н	Physici /Medic		EUNICE	- GALA	1 -			Month © 8	Da / 4		1'11 F A
7	Examin		4a. Facility Name (If not institution, give street a CRESCENT CITIES			4b. City, Town, or	r Location of De			. County of Deat	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i		If Under 1 Year Months Days		in (Month f	Day Vear		hplace (State or Foreign
ed).	Director		Usual Residence of Decedent	[⊠] F 70	Yrs.			Feb. 1	6, 1	938 Fran	nklin, VA
	ryland how		10a. State 10b. County		y, Town or Lo						10d. Inside City Limits
	he Ma '8a-f s	ecto	Maryland Prince Georg	e's	River					-	1 X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 4409 East West Hwy			10f. Zip Code	20737		10g. Ci	tizen of What Co USA	ountry?
	r deatl	ınera	11. Marital Status 12. Was	s Decedent Ever in U.:	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an. Mexican. Pu	(Specify Yes or N	lo-	14. Race - Ame Black, White	
36	rs afte	y Fu	If You	Yes 2 🖾 No es, Give ir or Dates:		1⊡Yes 2⊠No	Specify:	,			√hite
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Maryland	Ald be fental rked c	To Be	Unknown					Unkno		,	
lary	2 shou and the is mai	Г	19a. Informant's Name/Relationship (Type. Prin	,	1	ng Address (Street					
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nor	ages ent of h t: If ite y or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal	I II OIII State		sition (Name of natory or other place	1001	15/2008		ocation - City or	
Baltimore,	mit. Poartme		4 □ Donation 5 □ Other (Specify) 21. Signature of First al Semice Licensee	Meti	-	n Cremator 2. Name and Addres	1	13/2000			Virginia
<u>~</u>	permir Depar Impor any Ir		just to						. Hy	attsvill	more Ave. Le, MD 20781
			28a Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death e on each line.	n. Do not ent	er the mode of dyin	g, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
Ü.,	Physician /Medical		resulting in death)	ancylo	1	20					
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79	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequ	ience of):						
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	rtificat ng phy as the	Medic	IF FEMALE:								
gox	ath ce ttendir or use	ian/	in the nast 12 months?	es, outcome pf pregna Live birth 2 ☐ Fetal	I death 3	Ectopic pregnancy			12	23d. Date of del	ivery Day Year
P.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	1 Tyes 2 TNo 4□	Pregnant at time of de Unknown	eath 5	Other (specify)				WORT	Day Toal
	ss that gned b	by Pr	Part II. Other significant conditions contribution	g to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ord	w requires been signe should be		Seizure Bisond	ev				- 1	Yes 2	□ No 3□ Pr	obably 4 Unknown
Vital Records,	has be	Completed	anthrills						opsy	prior to o	topsy findings available completion of cause of
<u>a</u>			25. Was case referred to medical					1 Yes		death? 1 ☐ Yes	2 No
	ysicla is cert directe	To Be	examiner? 1 Tyes 2 No Hospital:	1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Othe		Death <i>Check onl</i> g Home 5 ☐ Res		6 ∏Other (Spe	cifu)
Division or	ing Pt. After th		1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe			ony)
/ISI	Attencr death	ficat	2 Puiside 6 Could not be	Place of injury - At ho	me, farm, stre		Tes ZUNO	28f. Location	(Street a	nd Number or Ru	ıral Route Number,
á	Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	4 [Tromode	building, etc. (Specify				10	own, State		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and	To the best of my know the basis of examinat manner stated.	wledge, death tion and/or in	occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the ccurred at the time	e cause(s e, date an	s) and manner as d place, and due	s stated. to the cause(s)
	To the within 2 To the complex	Ź	29b. Signature and fittle of certifier	0.4.0		29c. License			29d. Da	ite signed (Monta	h, Day, Year)
			30 Name and address of several	M·D	00a) (T		~U 8			8 14/08	
	\		30. Name and address of person who completed Saadia Husair	441	09 80	ust wes	it Hu	oy Ri	nerc	dale 1	10 20737
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 5 2008	82. Registrar's Signat	Local			U			

DHMH 17 Rev 1/2001

55	4		Amend #5 per	Fir G883 9/3 State of Mai	7/08 TT ryland / Dena	delible ink. artment of F	. Ensure A lealth and N	II Copies Iental Hve	Are Leg diene	ible.	
8002			for State Registrar 1. Decedent's Name (First, Middle, La			rtificate of			Reg. No U	08	26325
3	Physic /Medi		Philip W Georg					August	Day	Year	11:58a M
15	Exami		4a. Facility Name (If not institution, given 1316 Washington Irva			4b. City, Town, or Baltimon	r Location of Death e County			y of Death Ltimor e	
Jugus	Funeral Director		5. Social Security Number 6. 5 213 68 1990	ПМЗПЕ	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 23 1	h y, Year) 931	9. Birthp Cour Mary]	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	10d. Inside City Limits
H	72 hours after death with the Maryland natural", or items 23a or 28a-f show alfael Exercitive Invest be rectified at	ector	Maryland Baltimore	9	Baltimore (1 □Yes 2 No
09	Mith the same of 2 and 2	Funeral Director	10e. Street and Number 1316 Washington Irvir	ng Lane		10f. Zip Code 21220			10g. Citizen of USA	What Cour	ntry?
0	er death items 2	uner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
A S	ours after	þ	1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	1 XiYes 2 □ No If Yes, Give Year or Dates:	Korean	1∐Yes 2∭XNo	Specify:		Specia	ý: h	Mhite
60	- c -	Completed	15. Decedent's En (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of work	ing	16b. Kind of E	usiness/In	dustry
~ 6	i i i i i i i i i i i i i i i i i i i	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Steel	Worker	,		Bethlehe		el Corp.
C	d be filed vental Hygicked other	To Be	17. Father's Name (First, Middle, Last, James George)			18. Mother's Nam-		Maiden Surnai	ne)	
c	perilliore, Mary jail of permit. Pages 1 and 2 should be filed Department of Health and Mertial Hyg Important: If item 27 is marked other any injury or other traumatic event, 2008.		19a. Informant's Name/Relationship (Type. Print)	I	,	and Number or Rui	al Route Numbe	er, City or Town		
	of Heali	1 8	20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐	la 1/ 0/1	20b. Place of Dispo			Date	20c. Location		
4141	it. Page it. Page irtment irtant: It injury o	į,	4 ☐ Donation 5 ☐ Other (Special	y)	Metro Cren		August 14 20	008	Baltimor	e,Mary	/land
H	Dermi Departi any ir	0	21. Similar of Funeral Service Live	2sschn	L	assahn Fund 401 Belair	eral Home II Road Baltiu	more. Mar	vland 212	236	
A.			23a. Part 1. Enter the disease, or comshock, or heart failure. List only		he death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	w	consequence of):	c Corda	ouscul	001 1) 1¢	seasi		
	Examiner	<u></u>	Sequentially list conditions,	b. Due to (or as a	consequence of):					_	
•	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	ochooquonoo oij.						
9	box 600,000, and certificate be executed attending physician and for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence of):						
703	BOX 00100, eath certificate be exattending physician for use as the burial		IF FEMALE:	G					I		
		Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnanc Other (specify)	у			ate of delive lonth	very Day Year
	at the d by the etached	Physi	9 ☐ Unknown Part II. Other significant conditions	9 Unknown	not reculting in the u	adaduina sayan siy	on in Port I	23a Did to	phaces use cor	tribute to t	the cause of death?
3	w requires that the dispersion signed by the should be detached	d by	rait ii. Outer significant conditions (contributing to death but	not resulting in the di	idenying cause giv	en in Fait i.				bably 4 💆 Unknown
	e law rechast bee	Completed						24a. Was	sy	prior to co	opsy findings available ompletion of cause of
3	vital no vician: The locatificate his ector, page		25. Was case referred to medical				26. Place of Deat	1 □ Yes	rmed? 2 Z No	death? 1 ☐ Yes	2 XNo
5	ding Physician: th. After this certification of the control of the	To Be	examiner? 1 Yes 2 □ No		t 2 ER/Outpatier		er: 4 🗆 Nursing Ho	ome 5 Resid	dence 6 🗆 Ot		ify)
	ding P th. : After i	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Time of Injury	Worl	yat k? Yes 2 ∐No	28d. Describe h	now injury occu	rred	
	or Attendi or Attendi after death. Director: / in by the fi	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tov	Street and Num vn, State)	ber or Rura	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medical Ce	(Check only 2 Medical Exal	nysician: To the best of niner: On the basis of	examination and/or in	n occurred at the ti	me, date and place opinion, death occur	and due to the red at the time,	cause(s) and r date and place	nanner as : , and due t	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner state	ed	29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	<	1	Ihilyayttath N	W Deput	1	018	3667	/	April	14,2	2008
	12 x1		Philip Militelle	completed cause of dea	Haldmi	Print) 11CT-Lut	herville,	Md, a	21093)	
	Sta Regist	ate rar	31. Date filed (Nonth, Day, Year) AUG 1 5 2008	32. Registrar	's Signature		/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** a: W AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Seasons HOSPICE allstown Himore Year) -28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 3-10 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216-3327 USA interbourne Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐Yes 2 No è Specify: 3 ☐ Widowed 4 ☐ Divorced Blace Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any Injury or other trau once. Thomas Baltimore, MD ZIZK Hair 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State Voodlaun Cemelau 8-16 2000 Woodlaun MD

22. Name and Address of it cility Voughn C. Greene Finercom 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PERITONETI CANCINOMATOSI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 □No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) SONS Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HO SPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of After 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET REISTERSTOWN 25 Debrah 10×C6 MAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Ellen Hiller 2008 ĭ4, August 2:45 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Manor Care Towson Towson 5. Social Security Number 395-32-0996 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7/14/1936 1 □ M 2 🕱 F Days Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 ☐Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 1635 Thetford Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Quintin Hill Mamie Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kamala Carnes/daughter 1635 Thetford Rd, Towson, MD, 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. | 8/15/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. Mo1533 8717 Green Pastures Dr, Towson, MD, 21286 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Lug ouths disease or condition resulting in death) Lancer Due to (or a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Honknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Induportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Exercity and the northled at once.

Completed

Be

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit ed by the s been signed b should be deta his certificate h I director, page

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

the Hospital or Attending Physician;

Examiner Physician/Medical Completed Be Medical Certification: To After thi funeral To the Hospital or within 24 hours after death.

To the Funeral Director: After commetely filled in by the fur

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

examiner'

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 1 ☐ Yes 26. Place of Death (Check only one)

24a. Was an

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0061199

29d. Date signed (Month, Day, Year) Aug. 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Suite 209, Towson MD 21204 6565 North Charles Black 31. Date filed (Month, Day, Year)

ORIGINAL

State Registrar

5 Pending investigation

6 ☐ Could not be



			1 - For Amend #26, per Registrar	State of Ma erMD G882 8	ryland / Depa Ce/	artment of I rtificate of	Health and Death	Mental Hyç ه	giene Reg. No. 200	8 26329	
	Physici		Decedent's Name (First, Middle, La	Mary	Wooten	Harr	ell	2. Date of Dea Month	Day Ye		
200	/Medic Examin		4a. Facility Name (If not institution, gire		Wooden		or Location of Deat		4c. County of D		
			814 Chatfield F	Road		Jopp				ord Co.	
	Funeral Director		242-42-3124	Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day May 29	v, Year)	Birthplace (State or Foreign Country) Orth Carolina	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryl -f sho	ţ	Maryland E	Baltimore			Dund	a1k		1 □ Yes 2 🛣 No	
	h the	Director	10e. Street and Number 10f. Zip Code 10g. Citizer							Country?	
	23a c	ral	2111 Searles	Road			21222		United S	tates	
980	72 hours after death with the Maryland natural", or items 23a or 23a-f show deal Examinat must be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	Was Decedent of If Yes, specify Cub 1 □ Yes 2☑ No	Hispanic Origin? (S pan, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White	
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+	(Give life. L						
nd 2	tal Hygi	Be C	9 Years 17. Father's Name (First, Middle, Lest	")		JOK_	18. Mother's Nar	ne (First, Middle,	Maiden Surname)	Unkn.	
yla	ould by Ment	10	Paul L. Walte								
Maryland	nd 2 sh alth and 27 is n er traum		19a. Informant's Name/Relationship Mr. Linwood Walt			ng Address <i>(Str</i> ee Chatfie			r, City or Town, Stat Maryland	te, <i>Zip Code)</i> 21085	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ity Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo- cemetery, cren			Date	20c. Location - City		
ıltim			#□Donation 5□Other (Specify) Holly Hill Mem. Gdns. 8/14/2008 Middle River, MD								
21. Signature of Funeral Service Licenses Dunda-Ruck Funeral Home of Dunda-Ruck Funeral Home of Dunda-Ruck Funeral Home of Dundalk, Mary								Maryland 2	Inc. 21222		
23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.							ing, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RESpire	consequence of):	lusc		•••		Days	
	Examiner			. End sta						Years	
. /	pd tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D	consequence of):						
V	xecute and al-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
,09289	icate be executed physician and the burial-transit	edical E	· ·	d							
89)	ertifica ing ph e as th	Med	IF FEMALE:								
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at 1 9 Unknown	Pi Fetal death 3 □	Ectopic pregnand Other (specify)			23d. Date of Month	delivery Day Year	
S, P.	res that signed b	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?	
ord	w require been si should t	ted	C1272					1 🗗 🗘	es 2 □ No 3 □	Probably 4 Unknown	
of Vital Records,	hysician: The law his certificate has b I director, page 2 st	Completed						24a. Was a autop perfor	sy prior med? deatl		
ta	an; T	Be	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		Yes 2□No	
_	Physical this ce all direct	일	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	t 3 DOA Oth	oer:		ence 6 □Other (5	Specify)	
o uo	iding Phy th. After thi funeral o	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day,	Year) 28b. Time of Injury	Wor	ry at rk?]Yes 2 □No	28d. Describe h	ow injury occurred		
To the property of the part of							28f. Location (S City or Tow	treet and Number of n, State)	r Rural Route Number,		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month)								er as stated. due to the cause(s)			
	the state of the s						se number	- 2	29d. Date signed (M	onth, Day, Year)	
	Wandy Kluby MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						285		8/12/03		
	6		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, I	Print)	2016	100 4	2 12 1		
	Sta	0	Wendy (Clorsz - 31. Date filed (Month, Day, Year)	32. Restrar 2008	's Signature	17 UR 12	none	md	41206		
	Sta Registra		AUG 15	2008	w It A	bartes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 = State Amend Items 8,25 per fh/dr.,9882,08/15/09/th/Late of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20198 /Medical 4a. Facility Name (If not institution, give street, and number) County of Death 4b. City, Town, or Location of Death **Examiner** timor 11/13/1919 Birthplace (State or Foreign ring Cer Baltimore County If Under 1 Year | If Under 24 Hrs. Social Security Number Age/ 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2 □ F Hours 217 16 88 1919 Baltimore, Maryland 7300 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 920 Reverdy Road 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Prces: Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Plumbing Supply Salesman Plumbing Supply Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony J Herr Ruth Ruark 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4216 Fitch Avenue Baltimore, Maryland 21236 19a. Informant's Name/Relationship (Type. Print) William W Willis 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o Parkwood Cemetery July 31 2008 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licersee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, maryland 21236 23a. Part1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final busherme **Physician** disease or condition resulting in death) /Medical Due to (or as a chisequence of): Examiner Honoro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' To the Hospital or Attending Physician: we in 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ▼ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Funeral tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical win 24 h To the Fur and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 7/36/08 D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EVTAN ST FINE 308 DALTIMOSZE MD 21211 821 SHOAILS A HASHMIMD

Registrar

32. Registrar's Signature

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery Month Day Mont								•	Year						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bi 1/4 2008 /Medical 4a. Facility Name (If not institution, 4c. County of Death er Location of Death Examiner N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (h yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ★M 2 □ F Hours 225-48-2613 Director 68 1940 North Carolina March 19. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at N/A 1XYes 2 No Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 3654 Beech Avenue USA items 23a iner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣️No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status n"natural", or items edical Examiner m Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes ŽŽNo Specify. White þ Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Funiture Mover Moving Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be ment of Health and Mental Fred Hamm Ada Rupp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (0) Pearl Hamm Wife 3654 Beech Avenue, Baltimore, Maryland 21211 Health a Important; If item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 8/4/2008 Sykesville, Maryland ²² Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service License 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ill. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailu2e **Physician** hours /Medical Due to (or as a consequence of): Examiner Coronary arteries disease, S/P CABG 2006 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner y physician and as the burial-trans that initiated events resulting in death) Last c. Cerebral artery aneurysm years Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Chronic obstructive pulmonary disease years attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and the of certified 29c. License number 29d. Date signed (Month, Day, Year) Seely 31, 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 5601 Cochi Baltinion Raven Blud Registrar's Sign wite 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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			30. Name and address of person who co	r = y, 30	71 7	ospita	1) Dr-1	Cylin	1 Bir	עות ודוח
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 5 2288	32. Registrar's Signa	ture.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day __ Physician 6:20 Major Jackson Jr. 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Baitmore 8. Date of Birth (Month, Day, 6-11-1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours **№** M 2□ F 266-62-1252 66 FL. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Randallstown Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9063 Meadow Heights Road 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 No Specify: African-American Specify 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef. St. Agnes Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Major Jackson Sr. Martha Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is .07 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. Naomi Jackson/wife 9063 Meadow Heights Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Arbutus Memorial Park 8-15-08 Arbutus, Maryland 22. Name and Address of Facility Wilie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia min disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 Outpatient 3□ DOA Certification: To inneral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

Saltimore, Maryland 21215-0036

Vital

o

AUG 15 DHMH 17 Rev 1/2001

Piled (Month, Day, Year)

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

9005 Caton Ave

Baltimore Maryland

08-04137	
Dorothy Johnson	

rotny Johnson		1- For State	te of Maryland /	•	rtment of tificate of		id Menta	al Hygiei		200	18 2633
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,	Last)						e of Death		3. Time of Death
edical Exami	ner	Dorothy Id 4a. Facility Name (if not institution,		son	- 120	o. City, Town, o	- I - setten of		nth y 29, 20	4c. County of Deat	1242 hrs
		Johns Hopkins Bayviev	•		40	Baltimbre (Dealli		N/A	'
Funeral		5. Social Security Number	S. Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Ye			ate of Birtl	n(MM/DD/YYYY) 9. Bii Forei	
Director			1 M 2XXF	58	Yrs.	Months Day	/s Hours	Min. 7	/11/	1949 ^{cc}	Penn.
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locatio	n				 -	10d. Inside City Limits
* .	۱	Md. Balt	imore	Bal	ltimor	е					1 XXYes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	,			10f. Zip Code		-	10	g. Citizen of What Cou	ntry?
ith the 23a or notifie		2722 Lodgefa	rm Road	Francia III	2 142 14/00	212 Decedent of H		n? / Cracifu)	/aa as Na	USA	ican Indian, Black,
eath w items ust be	Funeral	1 Never Married 2 Mar	ried Armed Forces?	X No		s, specify Cuba				White, etc.	ican ingian, black,
after d	by Fi		rced If Yes, Give Year or Dates:			Yes 2X N					ack
hours "natur	ted	 Decedent's Education (Speci Elementary/Secondary (0-12) 	fy only highest grade com College (1-4 or 5		16a. Decedent' during mo	s Usual Occupa st of working life			ne	16b. Kind of Business	Industry
036 thin 72 ne.	Completed	12	Conlege (1 4 or o	,,,	Certi	fied N	ursin	ng Ass	st.	Health (Care
15-0 Tiled wi Hygie d other		17. Father's Name (First, Middle, L	-				18. Mother's	Name (First,	Middle, M	laiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of 94 land and Moulal Hygiewith 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	o Be	Eldridge Joh: 19a. Informant's Name/Relationshi			19b. Mailing	Address (Stre		L1a Co		ber, City or Town, State	e, Zip Code)
MD 2 d 2 shou Ith and I n 27 is numaric	-	Elisa DeFlem				,				elphia,Pa	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
re, l s l and of Heal of Heal		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		Place of Disposit rematory or other		emetery,	Date		20c. Location - City o	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Diphation 5 Other Sps	cffy:		Hill	Cemet	ery 6	3/9/20	800	Philadel	ohia, Pa.
Ball permit Depar Impor injury		1. Signature of Funeral Scrvick L	icense 4	TI	FS	tep Br	other	s Fur	nera	l Service timore, N	d. 21217
Physician		230 Part I. Enter the disease, or of failure. List only one cause of	omplications that caused	the death.	Do not enter the	e mode of dying	, such as car	rdiac or respi	ratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Hypertensive At			vascular Di	sease				Death
1	-	or condition resulting in death)	Due to (or as a conse	equence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						9
	xami	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						
Box 68760, death certificate be executed the attending physician and of or use as the burial - transit	cian/Medical Examiner		d								
60, ate be ex hysician e burial	ledic	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcom	o of prear	anov					23d. Date of delive	
Sox 6876 leath certificat e attending ph for use as the	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fet	al death 3	Ectopic	pregnancy		Month	Day Year
Box (e death or the attence ed for us	ysici	1 Yes 2 No 9 V Unkr	own g Unknown	time of dea	5 Oth	er (Specify)	-				
ires that the de signed by the ledetached f	y Physic	Part II. Other significant condition	ons contributing to death	but not re	sulting in the ur	nderlying cause	given in Part	t I. 2	3e. Did to	bacco use contribute to	process.
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached	ed by	Liver disease, obesity						_			bably 4 Unknown
cords, law requir has been s	Completed								4a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of
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on of Vital Records, ending Physician: The law requir ath. T. After this certificate has been si the funeral director, page 2 should b	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient		Other	Nursing Hom		Residence 6 Other	er:
1 of Ving Phy. After the	n: To	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	ry ear)	28b. Time of In		ury at Work?		Describe h	low injury occurred	
Division al or Attendi rs after death. al Director: //	catio	1 ✓ Natural 5 Pendi 2 Accident Invest	igation				Yes 2				De de Maria de Cita
Division pital or / ours after peral Dire	Certification:	deterr	not be inned (Specify)	jury - At no	ome, rarm, stree	, тастогу, опісе	building, etc.		r Town, S		ural Route Number, City
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Phy	/sician: To the best of my								
To the How within 24 h	Medical		iner:On the basis of exam and manner stated.	nination ar	nd/or investigati			urred at the ti	me, date a		
	2	29b. Signature and title of certifier	// NV				.M.E.			29d. Date signed (M May 30, 2008	orun, Day, Year)
		30. Name and address of person v	who completed cause of de	eath (Item	23a)					, 20, 200	
		Melissa Brassell, MD	Assistant Medical	Examin	ner 111 P	enn Street,	Baltimore,	, MD 2120)1		
S Regis	tate trar	31. Date filed (Month, Day Year)	32. Registrar	r's Signatu	re decett						
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DHMH 17 Rev 1/2001 OCME 2006

		•	For State Registrar	State of Marylar	•	artment of F tificate of			iene 008	26338
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		James	Jon	es			Angust	13 2008	7:20 P. M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death	,	4c. County of Dea	ith
			Baltimore Washing			Glen	Burnie	T:	Anne A	
	Funeral		5. Social Security Number 6. Sex 15	7. Age (In yrs.	57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		57 110.			August	15, 1950	Maryland
	yland Now		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Marie I	to	Maryland Anne Arı	undel	(Glen Bur	nie			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a		7885 Gordon Co	ourt Apt. 56	9		21061		USA	
	tems	Funerai		 Was Decedent Ever in L Armed Forces? 	J.S. 13.	Was Decedent of h f Yes, specify Cub	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 Yes 2 ANo If Yes, Give Year or Dates:		1 □ Yes 2 ☒ No	Specify:		Specify:	White
8	within 72 hours after death with the Maryland ene. then 'naturei', or items 23a or 28a-f ehow ta Madical Esarthar maat the codified at	edt	15. Decedent's Educ		16a, Dece	dent's Usual Occup	pation		16b. Kind of Business	s/Industry
75	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of won	king		,
7	d with giene er the	E O	10	College (1-401 5+)	Stock	cman			Grocery	
9	al Hy al Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I	Maiden Sumame)	
<u>y</u>	Ment arked	ျှ	William Robert	Jones			Anna	M. Redr	nond	
Jar	2 sh and is m		19a. Informant's Name/Relationship (Type						City or Town, State,	
a)	l and lealth om 27 ther t		Beverly A. Amiss 20a. Method of Disposition		760	Old Hera	ld Harbon	Rd., C1	ownsville	, MD 21032
Baltimore, Maryland 27215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or items 23a or 28a-1 ehow entry or other traumatic event, the Mudical Examination and Apple 2006.		1 ☐ Burial 2 🖾 Cremation 3 ☐ R		cemetery, crer	natory or other pla	1		20c. Location - City o	
≣	it. Partimer ritent		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		tro Cre	ematory,I			Baltimore	
Ba	Depa impo eny ii		Muschell	talleras	31	11 Mount	ain Rd.,	tallings Pasadena	Funeral H	ome, P.A. 2
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1	Physician		Immediate Cause (Final disease or condition	Pulmon	m	hoert	noion			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	typert				
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	al-tra	хаг	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):					
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89	g phys as the	edic								
Вох	ires that the death certific signed by the ettending p d be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnanc			23d. Date of de	elivery
œ.	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify) _	y 		Month	Day Year
P. O.	at the	hy	9 ☐ Unknown							
ď.	igned be de	Ď	Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	nderlying cause gr	ven in Part I.		N-A	to the cause of death?
ord	w requir been si should	ted						1 🗆 Ye	es 2 V No 3□F	Probably 4 Unknown
Ö	law lasb	npie						24a. Was a autops	y prior to	autopsy findings available completion of cause of
	The cate bage	Completed						perfor	ned? death?	s 2 No
<u> </u>	icien Sertifi ector	Be	25. Was case referred to medical examiner?	lospital: 🗘		- 04		th (Check only on	e)	
ō	this and dir	2	1 ☐ Yes 2 No ☐	lospital: Inpatient 2	ER/Outpatier 28b. Time o				ence 6 Other (Sp	ecify)
CO	ding P. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No	28d. Describe no	ow injury occurred	
Division of Vital Records,	Attending Physicien: r death. ector: After this certifics by the funeral director, i	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome, farm, str		7.03 2	28f. Location (SI	reet and Number or F	Rural Route Number
2	of or A	Certification:	4 Homicide	building, etc. (Spec	ify)	,,,		City or Town		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funsrei Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
	To the I	Med	29b. Signature and title of certifier	and stated.		29c. Licen	se number	2	9d. Date signed (Mor	ith, Day, Year)
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	100		30. Name and address of pelson who co			Print)	21//		right !	, 000
			John morris	10.301 HARZE	tal	Drive,	Jen Bn	mie. M	no: 2101	0].
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	P			75	,
	- riegisti	-	MAG T O FACE	The same of the sa	Es T					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06136 State of Maryland / Department of Health and Mental Hygiene Connor Richard Kohls Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month August 11, 2008 1556 hrs Physician/ Medical Examiner Connor Richard Kohls c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Reisterstown Dover Road & Tufton Spring Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 6. Sex Baitimore, Maryland 5. Social Security Number **Funeral** Hours Months Days March 12, 1993 15 212-39-1222 Director 1 X M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location Ob. Count 10a. State 1 Yes 2 X No Reisterstown Baltimore MD 28a-f show death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 28a-f notified at o Direct U.S.A. 21136 13011 Dover Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White Yes 2 X No specify: f Yes. Give Year Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturinjury or other traumatic event, the Medical Examin N/A Completed College (1-4 or 5+) Elementary/Secondary (0-12) Student 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathleen Ann Kraus Edward Charles Kohls Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ 13011 Dover Road Reistertown, Maryland 21136 Kathleen Kohls/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition t. James Church Came tery 08/16/08 Removal from State Manktan, MD Cremation 3 1 X Burial 2 Donation 5 Other Specify Ans and Address of Faculty Chapel & Cremation Services signature of Funeral Service License 8800 Harford Road Parkville, Maryland 21234 23a Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death failure. List only one cause on each line. a. Multiple Injuries /Medical Immediate Cause (Final disease aminer Due to (or as a consequence of): of condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical AMENDED UNPENDED attending physician or use as the burial 23d. Date of deliver The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 ✔ No 3 Probably 4 Unknown Records, P.O. 1 Yes δ 24b. Were autopsy findings available 24a Was an Completed prior to completion of cause of autopsy death? performed? No ~ has ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Division of Vital Other₄ Residence 6 🗸 Other: Scene Be Nursing Home 5 examiner? Hospital: 1 ER/Outpatient 3 DOA Inpatient this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury Motorcycle- motor vehicle collision 27. Manner of Death After Certification: Aug 11, 2008 1532 hrs Yes 2 ✔ No 1 Natura¹ Pending death. Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Dover Road & Tufton Spring Lane, Reisterstown, MD Hospital or A Could not be 3 Suicide (Specify) Local Street 4 Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 1 Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 12, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 1 Carol Allan, MD 31. Date filed (Month, Day, Year) State AUG Registra ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 1 tem 1 per dr., g882,08/15/08dhb.

Reg. No. 2 Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Eleanor** Kurtz **Physician** Gillus /Medical 4b. City, Town, or Location of Death
HACERS FOUN 4c. County of Death
WAS HINGTON 4a. Facility Name (If not institution, give street and number) **Examiner** BROADWAY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 101 Director 217-32-4539 MARCH 8 1907 PENNSYL WANIA Usual Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f show a notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director COTJCIHZAW HALFSTOW! 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 118 21740 PAULAGORD USA APT Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Mamed 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: WHITE ģ 3 ₩idowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOST OFFICE POSTAL 15 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY wools HAZEL HART ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM KURTZ **SO**~ AT 3 BROADWAY HAGHS DWD, MD 31740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ANATOMY LIFTS PELISTRY ANGUSTE, 2008 CUALYSAM SCHOCKH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MUNITORY GIFTS PECTISTRY SIE P HANOVER IND GIOTG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) CONGUSTIVE HEART FAILURE Physician /Medical Due to (or as a consequence of) Examiner THERO ECLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner YEBR TENSION as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ Ne 3 ☐ Probably 4 ☐ Unknown Completed EHROME 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EKNOCT U TOWN V - MD 19386 Mc

2008

31. Date filed (Month, Day, Year) AUG 1 5

MD

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Registrar's Signature

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Lakisha Lynch	

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State of Maryland / Department of Health and Mental Hygiene

ikisha Lynch		State of Maryland / Depar 1-For State Certi	tment of He ificate of De		al Hygiene Reg	200	18 2634
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
ledical Exami		LAKISHA LYNCH	Tab 03	y, Town, or Location of	Month August 9, 2	008 4c. County of Death	0525 hrs
		Facility Name (if not institution, give street and number) Maryland General Hospital		y, rown, or Location o Itimore	Death	4c. County of Beath	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	-	nder 1 Year If Under		(MM/DD/YYYY) 9. Bir	thplace (State or Foreign untry)
Director	- [213-88-8951 1 M 2 XF 32	Yrs. Mo	onths Days Hours	Nov. 2	25, 1975	MD
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			TIMORE				1 X Yes 2 No
Aaryland 28a-f show Lat once.	Director	MD BAL'. 10e. Street and Number		Zip Code	. 10g	g. Citizen of What Cour	ntry?
the M		1905 N. FULTON AVE.		21217		USA	
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ter dea		3 Widowed 4 Divorced If Yes, Give Year	1 Yes	2X No specify:		Specify: BLA	ACK
ours afi	d b	or Dates:	16a. Decedent's Us	ual Occupation (Give k		16b. Kind of Business/	
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5-0036 iled within 7 Hygiene. I other than	ompl	12TH 17. Father's Name (First, Middle, Last)	HOMEMAK		s Name (First, Middle, Ma	HOME	
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2121 rould be fill and Mental F is marked tic event,	P	19a. Informant's Name/Relationship (Type, Print)		ress (Street and Num	ber or Rural Route Numb	•	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		KENDRICK SHARPE 20a. Method of Disposition 20b. Pi	1322 W.		ST., BALTI	MORE, MD 20c. Location - City or	21223
Ore,			ematory or other pla			5712 O'DON	WELL ST.
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specify: 21. Signature of Funeral Service Coensee	MT. CARN		08/14/2008 WESLEY CHAV	BALTIMORE,	, MD 21224 MDT HM
Balt permit. Depart Impor injury		Week Chaish:	2007	7-09 EASTE	RN AVE., BAI	TIMORE, MI	
Physician		23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line	Do not enter the mo	de of dying, such as ca	ardiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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\/ = =	xam	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of)	:				
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60, ate be e hysicia	sician/Medical	X UNPENDED XAMENDED 7,8 per 23a, 27.	.28a-1. p	erME. 2884	t _{10/7/08 TT}	23d. Date of deliver	<u> </u>
687 ertifica ding p	an/l	23b. Was decedent pregnant in the past 12 months?	2 Fetal de	ath 3 Ectopic	pregnancy	Month	Day Year
Box 687 death certificathe attending ped for use as the	ysic	1 Yes 2 No 9 Unknown	5 Other (Specify)			
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Division of Vital Rec pital or Attending Physician: The ours after death. eral Director: After this certificate filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (Specify) reside		tory, office building, et	or Town, St		ural Route Number, City Fulton Ave
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the best of my knowledge one) 2 Medical Examiner: On the basis of examination an and manner stated.	d/or investigation, in	n my opinion, death oc	curred at the time, date a	and place, and due to t	he cause(s)
F S F 5	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
ord		Do-nu Int Ino		O.C.M.E.		August 10, 2008	
Chia		Name and address of person who completed cause of death (Item 2 Donna M. Vincenti, MD Assistant Medical Exam		nn Street, Baltim	ore, MD 21201		
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	Physici		1. Decedent's Name (First, Middle, Last) TON M. LUGO)	2. Date of Death Month	3. Time of Death
The state of the s	/Medio		4a. Facility Name (If not institution, give street and number) Seasons Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8 Date of Birth	4c. County of Death Baltimore County
	Director		561-86-0742 1X M 2 F 55 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	Months Days Hours Min.	Dec. 28,	Year) 1952 California
	he Maryla 28a-f shov offilied at	Director	Maryland Anne Arundel Glen Burn 10e. Street and Number		10	1 ☐ Yes 2 🗷 No
	23a or 3	al Dir	1002 Londonderry Drive	21061		nited States
2-0036	be filed with in 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the I "solical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sc If Yes, specity Cuban, Mexican, Puerto 1™Yes 2□ No Specify: Mex	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Hispanic
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aryie	es 1 and 2 sho ld b of Health and lent f Item 27 is marked r other traumatic e	ပို	George Lugo 19a. Informant's Name/Relationship (Type. Print) 19b. Mail	Frances I		City or Town, State, Zip Code)
, Na	and 2: ealth a n 27 is her trau		Pat T. Lugo / Wife 1002	Londonderry Dr.,		
nore	Pages 1 nent of H ant; If Iter ary or oth		I Li Buriai 2 El Cremation 3 Li Removal from State		^{Date} 15,2008 ²	Oc. Location - City or Town, State
Баптог	permit. Pages Department of Important; If It any injury or o		21. Signature of pure ryio lee	rematory, Inc. 2.Name and Address of Facility Irkley-Ruddick Fui 21 Crain Hwy.,S.E	neral Hom	Catonsville, Maryland ne, P.A. arnie, MD 21061
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ter the mode of dying, such as cardiac End Stage Re	enal Dîse	Interval Between
7,0078	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	N 0000 P 10 N 1 V	ucus s	CPOID
	To the hospital or Attenuing Prysician: The law requires that the death certific within 24 bours after clear. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to the funeral director.	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
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VISION OF	ending rin sath. or: After thi he funeral	ation: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	
	no the hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	e nosp 24 hou e Funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 4 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occur	, and due to the ca red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
,	vithir To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
	- d		30. Name and address of person who completed cause of death (Item 23a) (Type	H45931		August 13th 2008
	9		Debarah Flores 25 MAIN	,	LSTOWN 1	МР
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 5 2008 32. Registrar's Signature	Regall o		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26343 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** Anna P. Lejsiak July /Medical 31 5:35A 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8515 Esquire Road Baltimore Co. Edgemere 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ X E Yrs. 212-28-9110 95 Feb. 9,1913 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 X No Directo Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8606 Esquire Road 21219 United States Funeral iral", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify White "natural" th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Benarick Barbara Yancura ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Mrs. Barbara Piper (Daughter) 8607 Esquire Road Edgemere, Maryland 21219 Department of Health Important: If Item 27 any Injury or other troops. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o ... 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 8/2/2008 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. 21222 Dundalk, Maryland 23a. Part 1. Enter the shock, or head a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final **Physician** VO CUEPICO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No page 2 s certificate has autopsy performed?

Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify Residence 1 Yes 2 **....√**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 45105 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 1 5 2008 U66 (r.

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:12 PM **Physician** Walter Berkley Lowrey AUGUST 10,200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAUTIMORE SAINT AGNES HOSPITAL 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jul. 26,1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 84 Maryland 206-14-5511 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at Catonsville Baltimore 1 ☐ Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 412 Ingleside Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates 1943-45 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by White 3 Widowed 4 Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medi-a 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Automotive Assembly 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Frances Little William James Lowrev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 412 Ingleside Ave. Catonsville, MD 21228 Irene S. Lowrey - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 8-14-2008 Good Shepherd Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. Sulphur Spring Rd., Arbutus, MD 21227 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS Physician PHEMMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 □ Ectopic pregnancy Month Vear in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown LEUKEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has I page 2 s performed 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death.
I Director: After death. (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2003, 01 TENDER P 20656

101

State Registrar

ELEVITSKIY 900 CATON AUE, BAUTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** ~ANASA Aug 11:35 AM 208 /Medical)ALVATORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND

5. Social Security Number 6. Sex BALTIMORE MEDICAL LENTER N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1**3** M 2□ F Director 219-40-6903 65 Virginia 15, 1942 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, Inc Medical Examiner must be notified at 1 ∏Yes 2 TXNo Director Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Bayfront Dr. permit. Pages 1 and 2 should be filed within 72 hours after death \(\text{Department of Health and Mental Hygiene.} \)
Important: If item 27 is marked other than "natural" ---- any injury or other trainment. 21122 USA by Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 DXNo Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Barber/ Proprietor Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be V. Lanasa Mary ပ Sansone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Lanasa (Daughter) 1608 Coralie Ct. Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 8/19/08 4 Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LTI - ORGAN /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed DIFFICILE resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical MEUTROPENIA. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) P.0. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by AMOHOM P. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has certificate 2 No 1 □ Yes 2 **X**No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director: And in by the for 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001

within 24 hours a To the Funeral I

Medical

State

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated.

South

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Street

29c. License number

Baltimare,

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No:-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical Facility Name (If not institution, give s 4b. City, ation of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Age (**Funeral** Months Min. 1 □ M 2 🔀 F Davs Hours Director Arolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notifled at Funeral Director timore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What C 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 3 Widowed 4 □ Divorced Completed if Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, Be 0 19a. Informant's Name/Relationship 19b. Mailing Address Bural Route Number, City or Town, State, Zip Code) oad Place of Disposition (Name of cometery, grematory or other) 20a. Method of Disposition Location - City or Town, State Department of h
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death nediate Cause (Final **Physician** VEan disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Sursing Home 1 🗌 Yes 2000 Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) ours after death.
neral Director: After this
filled in by the funeral di this 27. Manner of Death

Natural

∠ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and little of certifie 29c. License number

State Registrar e and address of person who complete

AUG 1 5 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

evindo

ause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Z:05A.M nneth A I Fonso August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Co. Genera olumbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) s. last birthday) 5. Social Security Number 6. Sex 7. Age (In) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F ountry Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shore 1 Yes 2 No **Funeral Director** Maryland 10e. Street and Numbe 10g. Citizen of What Country? 1157 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: Black 2 3 Widowed 4 Divorced Completed other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. anito 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Maybir Old 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other of Date wh, State Department of I Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 301 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNG disease or condition resulting in death) Cancel /Medical Due to (or as a consequence of): Examiner Conce bone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the functer director, page 2 should be detached for use as the burish-transit attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗆 Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

State Registrar (Check only one)

29b. Signature and title of certifier

Shawn

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Cedar Lane

and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVONS

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20063653

Columbia, Maryland 21044

29d. Date signed (Month, Day, Year)

August 3, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12, 2008 10:15 PM August Lucille Miller Jean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year _ If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/30/1929 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🔀 F Maryland Director 78 215-24-2641 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with to f Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or sother traumatic event, the Wedical Examinational bone. USA 1807 West Ave. 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No Specify. Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James O'Brien Marion မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 West Ave. Dundalk, MD. Barbara A. Long (daughter) 21222 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/15/2008 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Sature of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD. 21222 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐ No 1 □Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 LOther (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this HOSPICE funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar's Signature State **AUG 15** Registrar

AUGUST

MILLER

Division or Vital Records, P.O. Box 68760.

AUG 15

2008

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 1- State Amend 19b, perInf G882 8/19/08 TTficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician \mathbf{A}^{M} HENRY **McCOY** AUGUST 2008 6:00 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2715 WOODLAND AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours Months Days 1**X** M 2□ F Yrs. Director 215-30-8990 76 01-07-1932 SC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2715 WOODLAND AVENUE Funeral 21215 USA . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1**X** Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Y No Specify. à Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OSHA INSPECTOR STATE OF MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEROY McCOY, SR. EVA HENRY မ 19a. Informant's Name/Relationship (Type. Print) Hajing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE McCOY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-14-2008 METRO CREMATORY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter line, Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificete be executed burial-trar Due to (or as a consequence of): by Physician/Medical the the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy signed by the atte be detached for Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Pres 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 Vis Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52313 8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W JOPPA R.D., LUTHERVILLE, MD 21093 CHARLES 2360 LOCKE MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

of Vital

Division

			For State Registrar	State o	of Maryla	•	artment of F rtificate of		Mental Hyg F	giene Reg. No 2008	26351	
	Physicia /Medic	_	Decedent's Name (First, Mide	,	A WEST	NEWTON			2. Date of Dea Month AUG 6	Day Year	3. Time of Death 1:40 P M	
	Examin											
			NATIONAL NAVA				BET	THESDA If Under 24 Hrs.	To Die (Die	MONTGO		
	Funeral Director		5. Social Security Number 311-20-7563	6. Sex 1 M 2 XF	7. Age (In yi	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec. 19,	v. Year) Co	thplace (State or Foreign ountry) ndiana	
	land ow		Usual Residence of Decedent 10a. State 10b. Count	у	10c. (City, Town or L	ocation				10d. Inside City Limits	
	Mary Fied a	호	TN Ande	erson		Dakridg	e				1X Yes 2 No	
	h the	Director	10e. Street and Number			Junitag	10f. Zip Code		2	10g. Citizen of What Co	ountry?	
036	th wil		301 Briarcliff	Avenue,	Apt. E	1	37830)		USA		
	ems er mi	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in orces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi		
	ours afte ral", or it Examin	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	urried 1 ☐ Yes If Yes, G	2 X No ive		1 ☐ Yes 2 ☑ No		, , , , , , , , , , , , , , , , , , , ,		White	
5-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted	15. Decede	ent's Education lest grade completed)		16a. Dece	edent's Usual Occup	pation during most of wor	rkina	16b. Kind of Business		
121		Completed	Elementary/Secondary (0-12) College (1-4or 5+) Atomic I							Atomic En		
12			17. Father's Name (First, Middle	2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2 (2		Admi	<u>nistrativ</u>		ne (First Middle	University Maiden Surname)	у	
<u>a</u>		To Be	Norval Joseph	,					McCormic	,		
ary		F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town. State. Zin C									
Š			Joyce Giffey/S	Sister		68 Mc	01 Tennys Lean, VA	son Drive 22101				
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	20b	Diana of Dian	Al		Date	20c. Location - City or	Town, State	
			4 ☑ Donation 5 ☐ Other	(Specify)		Tenness	ematory or other pla ity of ee	8-1	1-08	Memphis,	<u>rn</u> ssee Health	
	permi Depar Impo any ir		21. Signature of Fuheral Service	e Licensee	<i>[[]]</i>		2. Name and Addre Science C			-	ssee Health	
	THE REAL PROPERTY.		23a. Part1. Enter the disease,	or complications that	caused the de						Approximate	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of):									
2,09289	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Inscase or Injury) that initiated events resulting in death) Last	S c	(or as a cons					3		
	To the Hospital or Attending Physician; The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live 4□Preg 9□Unkr		etal death 3 of death 5	□Ectopic pregnanc □ Other (specify)	•		23d. Date of de Month	Day Year	
rds, l	quires the signed all be de	by	Trait it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Reco	ne law rec has beer ge 2 shou	Completed							24a. Was autop		utopsy findings available completion of cause of	
<u>a</u>	Physician: The la r this certificate has ral director, page 2		25. Was case referred to medic	221					1□ Yes	2 No 1 □ Yes	s 2□No	
<u>=</u>	ysicla s cert	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Innatient 2	□ FB/Outpatie	nt 3□ DOA Oth		ath (Check only of			
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io	endlin ath. or: Aff	atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
Divis	al or Atta after de i Directo d in by ti	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. Plac	e of injury - At ding, etc. (Spe	home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or Fi vn, State)	lural Route Number,	
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one) 1 Certify Medica	al Examiner: On the l	e best of my k basis of exam nner stated,	nowledge, dea ination and/or i	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
	ro the vithin ro the somple	Me	29b. Signature and title of certif	- // -			29c. Licens	se number		29d. Date signed (Mor	th, Day, Year)	
			N Now	>4	M	0	010	1240997	(VA)	8/7/	26	
	20		30. Name and rd ress of perso	n who completed cau	ise of death (It	tem 23a) (Type	, Print)		L NAVAL I		NTER	
	de	,	JOHN S THURBE						A MD 208			
	Sta Registr		31. Date filed (Month, Day, Yea		egistrar's Sig	gnature	10					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Vivian Nicholson 2. Date of Death August 2008 12:20P M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Genesis Perring Parkway Parkville 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🕱 F 125-32-0658 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore Parkville MD 1 Tyes 2 No 10f. Zip Code 21234 10g. Citizen of What Country? 10e. Street and Number U.S.A. 15 Astro Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐Yes 2 📉 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vera Rogers Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Astro Ct, Parkville, MD, 21234 Donna Nicholson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/14/2008 Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A 21. Signature of Funeral Service Licensee Mol5]3 8717 Green Pastures Dr, Towson, MD, 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2□No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 NO 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Leath 1 Vatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, the attending use for 1 been signed by the should be detached s certificate has be irector, page 2 s the

Physician

/Medical

Director

Funeral

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Medical Certification: To

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d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be netitied at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may Injury or other traumatic event, the Medical Examinational born once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

29b. Signature and title of certifie

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, &21 N. ENTAW St Frute 308 BALTIMORE MP 2/201

31. Date filed (Month, Day, Year) State **AUG 15** Registrar

4 ☐ Homicide

29a, Certifier



Division of Vital Records, P.O. Box 68760,

The Johns Hopkins Social Security Number 214-20-2603 Sual Residence of Decedent Oa. State MD. Oe. Street and Number 4610 EUGENE 1. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 12TH 7. Father's Name (First, Middle, La JOHN NOWOWI 9a. Informant's Name/Relationshi JEANNETTE M. 10a. Method of Disposition 1 Purial 2 Cremation	AVENUE 12. Was Deceder Armed Force 1 1 Yes 2 If Yes, Give Year or Dates s Education grade completed) College (1-4 of ast) EJSKI	Age (In yrs. Ia: 82 10c. City, BA nt Ever in U.S. \$?	Town or Loca LTIM 13. W If 16a. Decede (Give ki	DRE CIT	or Location of e City If Under 2 Hours FY D6 Hispanic Origonan, Mexican,	f Death 24 Hrs. 8. Min. J	Yes or No-	4c. Co	9. Birth Cou MA	npplace (State or Fountry) RYLAND 10d. Inside City L 1 X Yes 2 [
The Johns Hopkins 5. Social Security Number 214-20-2603 Joual Residence of Decedent 10a. State 10b. County 10b. County 10c. Street and Number 4610 EUGENE 1. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12TH 17. Father's Name (First, Middle, La JOHN NOWOWI 19a. Informant's Name/Relationshi JEANNETTE M. 10a. Method of Disposition	AVENUE 12. Was Deceder Armed Force 1 1 Yes 2 If Yes, Give Year or Dates s Education grade completed) College (1-4 of ast) EJSKI	Age (In yrs. Ia: 82 10c. City, BA nt Ever in U.S. \$?	Town or Loca LTIM 13.W I 16a. Decede (Give ki life, DC	Baltimore If Under 1 Year Months Days DRE CIT 10f. Zip-Code 2126 as Decedent of Yes, specify Cult Yes 2X No ent's Usual Occulated of work done	e City If Under 2 Hours TY D6 Hispanic Origonan, Mexican,	24 Hrs. 8. Min. J	(Month, Da UNE 2	10g. Citizer	9. Birth Could MA	hplace (State or Fountry) RYLAND 10d. Inside City L 1 X Yes 2 (
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21. Signature of Funeral Service Lic	censes	102								L HOME,	
1201 DUNDALK AVE. BALTIMORE, MD. 21222											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Date of delivery Month Day									the cause of deat		
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1 Natural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 3 ☐ Suicide 6 ☐ Could not be determined determined.							28a. Describe now injury occurred				
							28f. Location (Street and Number or Rural Route Number,				
4 Homicide	building,	etc. (Specify)					City or Tow	n, State)			
9a. Certifier 1 Certifying (check only 2 Medical E	Physician: To the bes	et of my knowl	ledge, death o	occurred at the t	time, date and	d place, and	due to the	cause(s) ar	nd manner as	stated.	
one)	and manner	stated.				an occurred					
9b. Signature and title of certifier	M	400 0									
1	/				R 2 0	00		11661	510	1,200	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANJUNATH MARKANDARA 600 North Wolfe St, Baltimore, MD, 212										
F See See See See See See See See See Se	any, leading to immediate ause. Enter Undertying ause. Clisease or injury lat initiated events sulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant condition PERIFFE A C	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events soutting in death) Last FEMALE:	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events soutting in death) Last Columbia	any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events southing in death) Last Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of):	any, leading to immediate ause. Enter Undertying ause (Disease or injury at initiated events sulting in death) Last Due to (or as a consequence of): Due to (or as a conseque	Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Due to (or as a consequence of): Comparison Due to (or as a consequence of): Due to (or as a consequence of):	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) August 10, 2008 Month **Physician** Erna P. Odenkirchen 10:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery Wilson Health Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 3, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F 94 577-44-2481 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Russell Avenue # 506 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Media Center Specialist Public Schools 17. Father's Name (First, Middle, Last) ages 1 and 2 should be file nt of Health and Mental H i; If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Emilia Stephan Edward Petrich မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type. Print) Edward W. Odenkirchen/Son 11920 Clover Knoll Road, Gaithersburg, Maryland permit. Pages 1 as Department of Hea Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematoriúm, Inc. Aug. 13, 2008 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01498 Coop 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Oremonth disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mD Due to (or as a consequence of) Examiner Due to (or as a consequence o Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Pouls 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day) 1 Natural 5 Pending 2 **N**O death. 2 Accident investigation 1 🗌 Yes To the Funeral Director: 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 07 Rural Route Number, 4 Homicide hours after Home

#506 Go : Jeers bus, mo 2:457

1 © Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mapper as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hone Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 404115 H. Robert per

Registrar

61

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. ROBERTBIRS (HBALH, WAS

2. Registrar's Signature

31. Date filed (Month, Day, Year) AUG 1 5 2

4081

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** Arthur Peyton, Jr. 1:20 PM August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Center Timonium Baltimore Co. 8. Date of Birth (Month, Day, Year)
Sept. 24,1940 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 11 M 2 □ F Yrs. **Director** 220-36-1657 67 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at Director 1 ☐ Yes 2K No Maryland Baltimore Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7927 Eastdale Road 21224 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X ☐ No Specify: 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 sho. Id be filed within Health and , ental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Maintenance Repairs 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Peyton, Sr. Josephine Barnes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any Injury or other tra Christine Peyton-Ely (Daughter) 7927 Eastdale Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from Sta Hilltop Service Corp. 8/16/2008 Towson, Maryland 4 Donation 5/☐Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 □Yes 2 🗶 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 🛣 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Type critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Resstrar's Signature docale State Wilson Registrar

Baltimore,

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Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 26356 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 210 **Physician** Helen May Pittinger HUGUST /Medical Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A General If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex Age (In yrs, last birthday **Funeral** Months Days Hours 1 □ M 2 🗙 🗙 213-09-5729 Director 88 Sept 18,1919 MD Usual Residence of Decedent 10b. County N/A 10d. Inside City Limits 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examilier must be redtiled at once. MD Baltimore XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4513 Wilmslow Road 21210 U.S.A. by Funeral 14, Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married /ナ*と/⋵ハ レとナ汁/* Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: White 3 XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired)

Seamstress Elementary/Secondary (0-12) Coilege (1-4or 5+) Self-Employed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Henry Bortner Lucy May Herndon ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Marlene S. Muddiman 11937 Sunflower Lane Richmond, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 Cremation 3 Removal from State 8/15/08 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee—Henss—Seitz Funeral 3631 Falls Road Balto, MD 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Pulmonary Sequentially list conditions, if any, leading to Immediate cause. Linter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed steno Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has burector, page 2 sl autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

m.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician GRANT MAJOR POWERS AUGUST 13, 2008 9:55 A. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8702 EMGE ROAD BAYNESVILLE BALTIMORE Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs 3/4/1920 NORTH CAROLINA Director 179-12-8380 ৪৪ Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "naturel", or Itsms 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BAYNESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8702 EMGE ROAD 21234 USA 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 271s marked other than "naturel", or Itams 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2√2 No Specify: ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC 7TH GRADE TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ WALTER POWERS MARTHA C. POWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3339C LAKESHORE CIRCLE

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date MTLLSFORO, DE 19966
20c. Location - City or Town, State ROBERT POWERS/SON 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. GARRISON FOREST VET. 8/18/2008 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) CELETERY 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC KIDNEY month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-translt attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

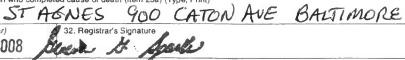
To the Funerel Director: After this certifica After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) AUG 1 5 2008



Registrar

AUG 1 5 2008

		For State Registrar	State of Ma			tment of Fificate of i			giene2 Reg. No.	008	260	359
Physici /Medi		1. Decedent's Name (First, Middle, La Cynthia Ann Reed	st)					2. Date of Dea Month August	Day	2008	3. Time of 8:15	
Examir		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death TOWSOY1				4c. County of Death Baltimore County		
Funeral Director		214 04 0000	ex 7. Age	e (In yrs. last birti 46		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da NOV • 27	h y, Year) , 1961	Coui	place (State ontry) On , Mar	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanter, but be notified to	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	e County	10c. City, Town						1	10d. Inside Ci	
	al Director	10e. Street and Number 134 Church Lane				10f. Zip Code 21	_030		-	n of What Cour ted Sta	-	
	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ♣️ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H 'es, specify Cuba Yes 2 No	ispanic Origin? (S nn, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White, pecify: Wh		
vithin 72 ho	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	fucation ide completed) College (1-4or 5- N/a		(Give kir life. DO	nt's Usual Occup nd of work done o NOT use retired HOME Mak	during most of wor f)	king	16b. Kind	of Business/In	,	
d be filed wental Hygie ked other t	To Be Co	17. Father's Name (First, Middle, Last) Raymond Robert Tr	le, Last) 18. Mother's Name (First, Middle, Maiden Surname									
and 2 shou lealth and N m 27 is mai		19a. Informant's Name/Relationship ((1100	1101/		Address (Street urch Lai	and Number or Ru Ne Co	ral Route Numbe				30
ant mer ury		1 Burial 2 Cremation 3 Removal from State Dulaney Valley Men. August 18, 2008 Timonium							ition - City or To nium , M a	,Maryland		
permit. Departi	2525 TOTA ROad TEMOTERMY SALLY FORM									n Ctr. 21093	,P.A.	
Physician /Medical	S	23a. Faryl. Efiter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. 9410	the death. Do note. SUHST a consequence o	m.		ng, such as cardiad		rest,		Approximat Interval Bet Onset and	tween
te be executed /sician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	3 Cultisequence o	,							
\$ £ €	dical	rosuning in doubly East	d.	a consequence o	T):							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 Live hirth 2 Fetal death 3 Ectopic pregnancy								d. Date of deliv Month	Date of delivery Month Day Year	
w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								te to the cause of death? Probably 4 Unknown		
	Completed				autopsy prior performed? death			24b. Were auto prior to co death? 1 □ Yes	impletion of c			
Physician: The this certificate is rall director, page	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient	3 □ DOA Othe	26. Place of Dea	ith <i>(Check only o</i> lome 5 Resid		ther (Special	ty) Hasf	762
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	27. Manner of Death 1 X Natural 5 Pending 2 Accident Nestigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Work? 4 Natural 5 Pending 2 Natural 5 Pending 4 Natural 5 Pending 4 Natural 5 Pending 5 Natural 5 Pending 6 Natural 7 Pending 7 Natural 8 Pending 8 Natural 8 Pending 9 Natural 9 Pending 1 Natural 9 Pending 1 Natural 9 Pending 1 Natural 9 Pending 1 Natural 9 Pending 28b. Time of Injury at Work? M 1 Pending 1 Natural 9 Pending 28d. Describe how injury occurred									
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the Hospital hin 24 hours a the Funeral npletely filled	edical	(Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examination and	death o	stigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner as a lace, and due to	stated. o the cause(s	3)
To with	N	29b. Signature and title of certifier	00)) -	7	29c. Licenso	04395	-		signed (Month,	-	
4		30. Name and address of person who				int)			0			1704

State Registrar

8:15 AM

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1-State Registrar amend #1 Per Phy G882 8/27698 ficate of Death	Reg	2008	26360								
Physici /Medio Examir		an	Freida Poth Frieda Roth	Date of Death Month	Day Year	3. Time of Death								
			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	August	13 2008 4c. County of Death	7:53p [™]								
and the	0.		4125 London Bridge Road Sykesville		Carroll									
	Funeral Director		5. Social Security Number 050-26-2760 C. Sex 1 Months Days Hours Min. Usual Residence of Decedent 6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Day, 19) Aug 4, 19	year) 9. Birthi 925 Ge	place (State or Foreign htry) ermany								
	ryland how	_	10a. State 10b. Counfy 10c. City, Town or Location		1	0d. Inside City Limits								
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show	he Ma 28a-f s otifivo	ecto	3,000,1220			1 ☐ Yes 2 TNo								
:	ath with t	Funeral Director	4125 London Bridge Road 21784		g. Citizen of What Cour	ntry?								
0	ritems	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,									
3-003b	iours a	d by	3√ Widowed 4 Divorced If Yes, Give 1 Yes 2 M No Specify:		Specify: whit	e								
<u>.</u>	n /2 h n "natu n dien	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of workin life. DO NOT use retired)	ng 16	food corre									
717	g with giene. er thai	Som	Elementary/Secondary (0-12) College (1-4or 5+) Cook		food serv	ice								
DESILITIOTE, INIGITYIANG ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantiner must be notified at any injury or other traumatic event, the Madical Evantiner must be notified at once.		To Be (17. Father's Name (First, Middle, Last) Xavier Bert1 18. Mother's Name Frances I		iden Surname)									
Mar)	h and I h and I ris ma trauma	ľ	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (<i>Street and Number or Rural</i> 19c. 19c. 19c. 19c. 19c. 19c. 19c. 19c.			•								
် မ	f Healt f Healt item 27 other t		Peggy O'Brien (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)		ille, MD 2.									
Daitimor	rages ment o ant: If i ury or		1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crest Lawn Memorial	8-08 Ma	arriottsvil	le, MD								
פונ	Departition Depart		21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause a each line.			Approximate Interval Between								
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. A cute Myolcardia Infanction 5 min											
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, 7	sit G	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuries are not as a convequence of):		-	75								
8	physician and the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): C. Due to (or as a consequence of): Due to (or as a consequence of):												
covous	hysicia he bur	Medical	d											
A O	iding p		IF FEMALE: 23c. If yes, outcome of pregnancy											
The law requires that the death certificate he consult	by the attendi	Physician/	23b. Was decedent pregnant in the past 12 months? 1	23d. Date of deliver Month	ery Day Year									
U, o	been signed by the should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat										
בייל בייל ביילים ביילים	peen s		Mrone Obstructive fulmonary Disease	1 Pes	2 □ No 3 □ Prot	oably 4 🗍 Unknown								
	cate has bage 2 s	Completed	- Hyper tension	24a. Was an autopsy performe 1 □ Yes 2 □	d? prior to co death?	psy findings available mpletion of cause of 2 \sum No								
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al or Attending Physician: s after death. Il Director: After this certifica	s after d al Direct ed in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
the Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the funeral properties of the funeral pro	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau ed at the time, date	se(s) and manner as s and place, and due to	stated. the cause(s)								
Tot	To the comp	Me	29b. Signature and title of contifier : 29c. License number 29c. License number D3U298	29d	Date signed (Month,	Day, Year)								
	N	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	//	- uj no i	4 2008								
	Stat	te	Robert Neil Kass, MD 410 Malcolm Drive Suite C 31. Date filed (Month, Day, Year) Je. Registrar's Signature	- West m	inster, MI	21157								
	Registra	_	AUG 1 5 2008 Section & Sparte											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Paul Allan Richardson Month 04:25 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAL IMORR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 3, 1931 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 57 Maryland Yrs. Director 214-56-6406 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits or 28a-f show The Madical Examiner must be notified at MD Baltimore Highlands 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2906 Louisiana Ave 21227 **USA** 238 filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore. Maryland 21215-0036 ò White 1 Yes 2 No þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NewHolland Rental Sales Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H lent: If item 27 Is marked ott Bernard B. Richardson Edna Dash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Richardson/Wife 2906 Louisiana Ave., Baltimore Highlands MD., 21227 other 20b. Place of Disposition (Name of __ cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Importent: If its sny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Cem. 8/16/2008 Glen Burnie, MD. 21. Algnature of Funeral Service Licensee AMBRUSE AFUNERALLY HOME OF LANSDOWNE 2719 Hammonds ferry RD., Lansdowne, MD. elactoral 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Atherose Priysician /Medical Due to (ur as a consequence of) Examiner learc Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Due to (r as a consequence of) Completed by Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 400 To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 Medical Certification: To 3 DOA o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 TYes 2 No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner. On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated.

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

K. Tonya Mason, M)

1 5 2008

1000 m

Registrar

DHMH 17 Rev 1/2001

32. Registrar signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

29c. License number

1)56418

St. ainis Dospital, 900 Caton Ave, Baltimore MD 21229

August 12 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Physician Joan Carroll Mullikin Reid August 11:40pm M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9671 Devedente Drive Owings Mills Baltimore 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 F 217-24-5211 04-04-1928 Director 80 ΜÃ Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner runst be notified at Director 1 ☐Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9671 Devedente Drive 21117 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 72 hours after 1 Never Married 2 Married 1 □Yes 2 No <u>ک</u> Specify Specify. 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) 6 years Teacher Kent Co. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Mullikin Anna C. Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Reid (son) 23 Water Grant St. Apt. 8-K Yonkers, NY 10701 20a. Method of Disposition

1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If Ite Injury Carroll Cremation, Inc. 8-13-2008 Hampstead, MD 21. Signature rvice Licensee of Funera 6 22. Name and Address of Facility Reisterstown, MD J. Wayne Osterling | ELINE FUNERAL HOME 11824 Reistertown Road art 1. Enter the vis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause of each line. Approximate Interval Between Onset and Death 23a. Immediate Cau (Final disease or condition resulting in death) TATZATE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ate has been sign page 2 should be 2 No 3 Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 🗷 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this 6 ☐ Other (Specify) funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; of the foundation of the found 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9

Registrar

Medical

- lavio 31. Date filed (Month, Day, Year)

30. Name and address of person who

and title of certifier

Kruter

29a, Certifier

29b. Signati

(Check only one)

Crossroads Dr egistrar's Signatur

ompleted cause of death (Item 23a) (Type, Print)

and manner stated

ORIGINAL

Ste 340

29d. Date signed (Month, Day, Year)

Owings Mills, MD 2111

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Amend #18 per FH g882 8/15/08 TT State of Maryland / Department of Health and Mental Hygiene 2 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 11001M Honry Scutt 0 00 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Randallstown Slasons Hospice - Northwest Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day 204 Birthplace (State or Foreign Country) **Funeral** 228.50.9519 Months Yrs 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1**⊠**Yes 2□No MD or other traumatic event, the Medical Examiner must be notified Funeral Director 10g. Citizen of What Country? 10e. Street and Number 3716 Howard Park Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify Be Completed by Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer General Electric 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Scott indSa ၉ 19a. Informant's Name/Relationship (Typę. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Park Avenue Baltimone MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 180 OWINGS rnson Forest 4 Donation 5 Dother (Specify) . Greede Fungral 22. Name and Address of Facility Vaughon (21. Signature of Funeral Service License m 8728 Liberty Road Kandallstonin MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, and as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician schemic cardiumyona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a, Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO(1110 1 ☐ Yes 2 ☑No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6/8/08 160680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUNELSUN 7 W HUN S+ Lelitzanun, MD 21136 E 31. Date filed (Month, Day, Year) AUG 1 5 2008 2. Registrar's Signature State Registrar

Amend #18 per FH g882 8/15/08 TT State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12 m 03:47 AM AUG 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES HOSPITAL BALTIMORE SAINT 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 □ **K** 214-50-007 Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 res 2 No Directo timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 LSA Funeral 14. Race - American Indian, "natural", or items dical Examiner mi Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes No ò Specify: Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname Bernice Forbes 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stoke KITKRd, erri <u>|10.MI)</u> 20a. Method of Disposition 1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee W01313 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACINETOBACTER PNEUMONIA **Physician** DAYS /Medical Due to (or as a consequence of): Examiner BREAST CANCER METASTATIC Monms Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1∐ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Indicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Malling. AVG 12m P22257 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGNES HOSPITAL, 900 S. CATON AVENUE BALTIMORE MALLIKA · ANGITIPALLI 31. Date filed (Month, Day, Year) AUG 1 5 2008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Legible in Black Indelible Ink. Ensure All Cop Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26365

		1- For State Certificate of Registrar Certificate of	Death	Reg. No.	00 2000
Physic		1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
al Exam	ımer	Dillion For Other	Oit. To a land of Day	August 4, 2008	2110 hrs
		5406 Gwynndale Avenue	 City, Town, or Location of Deat Gwynn Oak 	th 4c. County of De Baltimore C	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr		
Director		217-27-5861 1 M 2 F 18 Yrs. Usual Residence of Decedent	Months Days Hours Mi		Country) IMD
any		10a. State 10b. County 10c. City, Town or Locatio	n		10d. Inside City Limits
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	b	MD Baltimore Baltin	we		1 Yes 2 No
Maryl. 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	-
th the 23a or notifie	Ö	150d Langford Rd.	21207	USA	
ath wi items ist be	Funeral	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puert		nerican Indian, Black,
fier de F., or Dec. mu	F.	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	es 2 No specify:	Specify:	Black
lours a natura xamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during more during mo	s Usual Occupation (Give kind of st of working life. DO NOT use re		ss/Industry
36 in 72 h han "r lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	- 1		e o and
d with	l e	17. Father's Name (First, Middle, Last)	Studen +	E lectr ne (First, Middle, Maiden Surname)	ONIC
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important is I item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be (Duayne Curbean	Show	Hel Mc Duf	fy
D 27 Should and Me 7 is ma	유			Rural Route Number, City or Town, St	· · · · ·
and 2 lealth tem 2 tem 2 traum		Shan te McDuffy/Mother 1552 20a. Method of Disposition 20b. Place of Dispositi		Date 20c. Location - City	
nore ages 1 nt of F it: If i		1 Burial 2 Cremation 3 Removal from State crematory or othe		-12-08 Baltima	
Baltimore, permit. Pages I an Department of Hea Important: If ite njury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee() 22. Na	morror out o me and Address of Facility Va	lughn c. Greene	
m Pe mi			28 Liberty 1	Rd. Randalistu	in MD 21133
ີhysician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest, shock, or heart	pproximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) A Multiple Gunshot Wounds Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of):			
14/12 =	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
n and ransit		d.			
760, cate be exi physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	
68760, certificate be nding physici		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Feta	death 3 Ectopic pregn		Day Year
or after after	ysician	1 Yes 2 No 9 Unknown	er (Specify)		
D.O. Buthat the dedetached f	, Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
F. P.C ires that signed l	d by	II		1 Yes 2 No 3 P	robably 4 Unknown
cords law requi	olete	°			autopsy findings available to completion of cause of
of Vital Records, ng Physician: The law require free this certificate has been si meral director, page 2 should b	Completed			performed? death 1 ✓ Yes 2 No 1 ✓	
tal Recition: The certificate	Be	25. Was case referred to medical examiner?	26.Place of Death (Check		
1 of Vi ling Physi After this funeral dii	۵	1 Yes 2 No Inspire 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		ng Home 5 Residence 6 ✔ Ot 28d. Describe how injury occurred	her: Scene
on on cending ath.	tion	1 Natural 5 Pending Aug 4, 2008 2059 hrs	1 Yes 2 ✓ No	Subject shot	
∞ ≤ 5 9 5	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (Street and Number or	Rural Route Number, City
E 8 E	Set	4 Momicide determined (Specify) Local Street		or Town, State) 5406 Gwynndale Avenue, Gwynr	Oak, Md.
Fu Fu		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurre one) Medical Examiner: On the basis of examination and/or investigation			
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (A	
		Mull de	O.C.M.E.	August 5, 2008	
	}	30. Name and address of person the completed cause of death (Item 23a)			
7		Russell Alexander MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, M	1D 21201	
St		31. Date filed (Month, Day, Year) AUG 1 5 2008			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** (Juo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2510 RobbSt Ba +more If Under 24 Hrs. 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Hours Min 1□**X** 2□ F 219-52-3710 Usual Residence of Decedent Yrs Director -1949 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ es 2 ☐ No by Funeral Director timore Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene, College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Box 68760,≤ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 D No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has breaking the rector, page 2 s autopsy 1 ☐ Yes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this nours after death.

neral Director: After this
filled in by the funeral d 27. Mayiner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name

and address

2008

31. Date/filed (Month, Day,

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&C State of Maryland / Department of Health and Mental Hygiene 2 G882 Certificate of Death Reg. No. 1 - For State Registrar nt's Name (First, Middle, 2. Date of Death 3. Time of Death **Physician** /Medical Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign (In_vrs. last birthday) **Funeral** Months Days 1 **2** M 2 □ F Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner mast be notified at 1 Nes 2 No Completed by Funeral Director more 10e. Street and Number 10g. Citizen of What Country? 6 be filed within 72 hours after death with "natural", or items 23a 12. Was Decedent Ev Armed Forces? 1 Yes 2 ☐ No If Yes, Give Was Deceden if Yes, specify nt of Hispanic Origin? (Specify Yes or Nov Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 lf Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working College (1-4or 5+) is marked other 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important; If item 27 is any injury or other trauonce. Baltimore, Location - City or Town, Sta Baltimore, MD Method of Disposition **21224** 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State of Funeral Service License 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of typing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) detached 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No Division of Vital 1 ☐ Yes 2 👿 No To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\textbf{X} \end{array} \) Other (Specify) \(\text{HOSPICE} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours ; within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exam wheer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Yea

AUG 1

5

6:55

AUGUST

SMITH

RUSSELL

32. Registrar's Signature

/Medi	ian	1. Decedent's Name (First, Middle, L Vivian E.							P. Date of Dea Month	Day	008 Ye	3. Time of De 20:49
Examir		4a. Facility Name (If not institution, gi	Swigert		4b. City	. Town. or	Location of D		Aug 1	* T	County of [
Examili	ier	Univ. of Mary		ical Sys	,		Baltin		€			
Funeral Director		5. Social Security Number 6. 219–18–6058	_ 12	e (In yrs. last birthda) 83 Yrs.	/) If Unde Months	or 1 Year Days	If Under 24 I Hours N	Hrs. 8	Date of Birth	5 ^{Year)}	9. M .	Birthplace (State or Fo Country) a ryland
		Usual Residence of Decedent		140. Ott. T.								
ehove III	5	10a. State 10b. County MD Anne A	rundel	10c. City, Town or I		e						10d. Inside City L
ital Hygiene. Id other than "natural", or terms 23a or 28a-f ehow event, the Medical Exeminer must be notified at	Funeral Director	10e. Street and Number			10f 7i	ip Code				10a Citi:	zen of Wha	
3a or	<u></u>	7873 Americana	Circle			21061				US		ii oouniiy.
E B	ner	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Dece	edent of H	ispanic Origin? In, Mexican, Pi	(Speci	fy Yes or No-			American Indian,
or to	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give	No	1 Yes		Specify:	Jeno Mi	can, etc.)		Specify:	White, etc. White
2	d by	3 Widowed 4 Divorced	Year or Dates:									
inal ledici	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)	16a. Dec (Giv life.	edent's Usu e <i>kind</i> of wi DO NOT u	ual Occupi ork done d us <i>e retired</i>	ation du <i>ring</i> most of f)	working	,	16b. Kir	nd of Busin	ess/Industry
h and Menta! Hygiene. 7 is marked other than " fraumatic event, the Mes	E	Elementary/Secondary (0-12)	4 College (1-4or	Adm:	inist	rator	Í			Mot	or Ve	hicle Adm.
othe ent,	BeC	17. Father's Name (First, Middle, Las	t) Unk				18. Mother's	Name (/	First, Middle,	Maiden	Sumame)	Unk
rked itic e	ToE											
t Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship Leonard Swigert	(Type, Print) - Husband	19b. Mai	ling Addres	s (Street a	and Number or	Rural F	Route Numbe	r, City or	Town, Sta	te, Zip Code) e,MD 21061
tem 27 other tr			- Indobatic				ia CILC					
or of		20a. Method of Disposition 1 Durial 2 Cremation 3		20b. Place of Disp cemetery, co	ematory or	other plac		Dat				y or Town, State
rtant		4 Donation 5 Other (Spec	•	Anatomy								r, MD
Department of I Important: If Ite any injury or of once.		21. Signature of Funeral Service Lice Brent Bard		diam			Dr., Su		_		_	stry, 7522
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Medical and the private transit	al Examiner	flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respira Due to (or as	a consequence of): atory Fa: a consequence of): Fibrila a consequence of):								24 hrs
attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	□Ectopic p					2	3d. Date of	f delivery Day Year
ed by the a	ysl	1 ☐ Yes 2 █️No 9 ☐ Unknown	9□ Unknown	une or death 3	□ Other (s)	pecity)						
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has been sign pe 2 should be	ошо						26. Place of I	Death (C				165 2 10
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is certificate has been sign director, page 2 should be	Be	25. Was case referred to medical examiner? 1 XYes 2 □ No	Hospital: 1 Vinpatie	nt 2 ER/Outpatie	ent 3 Do	OA Othe	a 🗌 Nursin	g Home	5 Resid	01100		
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this certificate has been sign al director, page 2 should be	To Be	examiner? 1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da)	y Year) 28b. Time Injury	of :	28c. Injury Work	at	280	d. Describe h	ow injury	i Number o	or Rural Route Number,
uouts aret veath. Funeral Director: After this certificate has been sign ely filled in by the funeral director, page 2 should be	Certification: To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Natural 6 Could not to determined 29a. Certifier (Check only 2 Medical Example)	28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ry Year) 28b. Time Injury ury - At home, farm, so. (Specify) of my knowledge, deal examination and/or in	M treet, factor	28c. Injury Work 1 1	rat rat r? res 2 No	286	f. Location (S City or Town	ow injury treet and n, State)	Number o	or Rural Route Number,
4 hours after death. Funeral Director: After this certificate has been sign ely filled in by the funeral director, page 2 should be	To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigatic 3 Suicide 6 Could not to determined 4 Homicide 29a. Certifier (Check only one) 1 Certifying P 2 Medical Examiner	28a. Date of Injunction (Month, Date) 28e. Place of Injunction	ry Year) 28b. Time Injury ury - At home, farm, so. (Specify) of my knowledge, deal examination and/or in	M treet, factor th occurred	28c. Injury Work 1 1 y, office I at the tim n, in my op	rat ?? res 2 □ No se, date and planinion, death of	286	f. Location (S City or Town d due to the c at the time, d	ow injury treet and n, State) ause(s) ate and	d Number of Numb	or Rural Route Number, or as stated, due to the cause(s)
net deam. Mector: After this certificate has been sign in by the funeral director, page 2 should be	edical Certification; To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Natural 6 Could not to determined 29a. Certifier (Check only 2 Medical Example)	28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ry Year) 28b. Time Injury ury - At home, farm, so. (Specify) of my knowledge, deal examination and/or in	of M treet, factor th occurred nvestigation	28c. Injury Work 1 1	rate (?) Yes 2 No No, date and plainion, death or	286	d. Describe h	treet and n, State) ause(s) ate and	and manne place, and	or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 13, 2008 2:10 P. M Frank Sica /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frankford Nursing Home Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 82 212-28-6322 Director June 3,1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Experiment rest by motified at Maryland N/A Baltimore City 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit, Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any ounce. 5502 Knell Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ I If Yes, Give Year or Dates: 1 □Yes 2 X No White Specify WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaner Clothing 12 yr's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benson Sica Rosaria ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taka Hara Sica - Wife 5502 Knell Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 16,2008 Timonium. MD Dulanev Vallev 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Anoxi C enco disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Exami Orgs tate Can Car burial-trar attending physician vascular Arril Physician/Medical Cerebro the as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Certification: To After this funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

within 2

Box 68760,

P.0.

Division of Vital Records,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali Mirebrahimi-Tafreshi

AUG

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0066508

821 N. Eutaw St. Suite 405 Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 14, 2008

			For State Registrar	State of Mai	ryland / [-	rtment of H		nd Me	_	iene _{eg. No} 2 } {	18	26370
ľ	Physicia	an	Decedent's Name (First, Middle, L.	ast) Donna	F.		Stern			2. Date of Deat			3. Time of Death 4:45 P M
J	/Medic Examin		4a. Facility Name (If not institution, gi	ive street and number)			4b. City, Town, or		Death	August	4c. County of	of Death	ndel Co.
- On-	Funeral			Sex 7. Age	(In yrs. last bir		Glen If Under 1 Year Months Days		4 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
į.	Director		217-40-5481 Usual Residence of Decedent	1□ M 2☑ F 65	· · · · · · · · · · · · · · · · · · ·	Yrs.		1,02.0		(Month Day, April 1	2,1943	Pen	nsylvania
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	tor	10a. State 10b. County	altimore	10c. City, Tow	n or Loc	ation Edgemer	e.				1	0d. Inside City Limits 1
	vith the a or 28a-	Directo	10e. Street and Number				10f. Zip Code		219	1	Og. Citizen of W		*
	death v	Funeral	7306 1/2 Hughes	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	as Decedent of Hi Yes, specify Cuba			ify Yes or No-	14. Race		an Indian,
2-0036	urs after al", or ite Exa⊞ine	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:)			Specify:		, , , , , , , ,	Specify:		White
2	be filed within 72 hours after death with the Marylan ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest g			(Give k	ent's Usual Occupa ind of work done o O NOT use retired	furina most o	of workinį	g	16b. Kind of Bus	siness/Ind	dustry
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Mar	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship Stacy Percoski	(Type. Print) (Daughter)	- 1		Address (Street a				; City or Town, S burg, M		^{Code)} 1784
ore,	Pages 1 and 2 nent of Health a int: if item 27 is iry or other trai		20a. Method of Disposition Fi Burial 2 □ Cremation 3	☐Removal from State	cemete	ry, crem	ition (Name of atory or other plac	1	Da		20c. Location - (•	
altım	permit. Pages Department of Important: if i any injury or o		4 ☐ Donation 5 ☐ Other (Spec 21. Signatur, of Funeral Service Lice		Meadow		ye Mem. P Name and Addres ida-Ruck		-	/2008		_	Maryland
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	Physician		shock, or hear failure. List online Immediate Cause Final disease or condition	y one cause on each line	a wa	d	the fi	7	ardiae or	respiratory and	551,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	сопѕедиелсе	ys:		7					
7	ted sit	Examiner	Sequentially list conditions, if any, leaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to or as a	сопѕефиепсе	of):							
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09/90	certificate biding physic	ledica		d									
POX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death		Ectopic pregnancy Other <i>(sp</i> ec <i>ify)</i>				23d. Date Mor		ery Day Year
л Э	that the ded by the	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	not resulting in	n the un	Narlying cause give	on in Part I		23e Did tol	nacco use contri	hute to ti	ne cause of death?
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Lecc	g & C	Completed								24a. Was a autops perfori	sy p med? d		psy findings available mpletion of cause of
VII all	'sician: The law s certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical examiner?						of Death	1□ Yes (Check only on		∐Yes	2 No
0	Phy rald	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	28b.	itpatient Time of Injury	3 DOA Othe	4 Murs			ence 6 Other		y)
ISION	Attending r death. ector: After by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be 28e Place of injur			M 1	Yes 2 □ No		Bf. Location (St	reet and Numbe	er or Rura	Il Route Number,
2	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 ☐ Homicide determined	building, etc.	(Specify)					City or Town	n, State)		
	he Hosp in 24 hou he Fune pletely f	Medical	29a. Certifier 1 ★ Certifying F (Check only one) 2 ★ Medical Exa	Physician: To the best of aminer: On the basis of e and manner state	examination ar	e, death id/or inv	estigation, in my o	ne, date and pinion, death	h occurre	nd due to the c d at the time, d	ause(s) and mai late and place, a	nner as s ind due t	tated. the cause(s)
	To t To t	Z	29b. Signature and title of certifier	ΛΙλ			29c. License		-		9d. Date signed		
•	15		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, P	rint)	1	0		0 0.	-	MD 21061
ķ	Sta		31. Date filed Month, Day, Year	32 Registrar	's Signature	Ana	en High	way	- ک	w. ol	en byrn	R 1	MO 406/
	Registr	ar	AUG 1 5 2	008 Spean	1 100	1		,					

			1 - State of Ma	aryland / Depa <i>Cel</i>	artment of F <i>rtificate of</i> I	lealth and N <i>Death</i>	lental Hygie Bea	ne No.2008	26371
	Physici	an	1. Decedent's Name (First, Middle, Last) Leonora Sheldo	_			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	0	4b. City, Town, or	r Location of Death		8, 2008 4c. County of Deat	410 PM
**	Franci		Northwest Has point 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		Sals To		Baltin	thplace (State or Foreign
ı	Funeral Director		217-16-1133 1□ M 2⊠F	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Apr 30, 1	923 P	ennsylvania
	yland now		Usual Residence of Decedent 10a. State 10b. Counfy	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f sh	Director	MD Baltimore	Pi	kesville				1 ∐Yes 25∑ No
	with the	D.	10e. Street and Number 4739 Mary Knoll Road		10f. Zip Code 21208	0	10g.	Citizen of What Co	
	tems 2	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?			lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	erican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, The Medical Exercitive controlled an once.	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	lo	1 □Yes 2√∑No	Specify:	, ,	Consider	White
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occup	durina most of worki	ng 16b	b. Kind of Business/	
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pug	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid		
aryle	should nd Mer marke nmartic	ျှ	Giacomo Bellafiore 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	na Address (Street	Maria and Number or Bura	Accardi al Route Number, Ci	ity or Town State :	Zin Code)
Š,	and 2 ealth a n 27 is		Helen Bellafiore Sister	4739	Mary Knol	ll Road I	Pikesville		208
nore	ages 1 ent of H t: If ite y or otl		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	20b. Place of Dispo		1		. Location - City or	Town, State
Baltimore, Maryland 21215-0036	rmit. P partme portan y Injur		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Carroll C	remation 2. Name and Addres		′08 Ha 324 Reista	ampstead, erstown Re	
<u> </u>	82 = 8		Stephen M. Jour		INE FUNEF	RAL HOME	Reisterst		21136
Eq.	Physician	i 18	23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line immediate Cause (Final	е.	-				Approximate Interval Between Onset and Death
	/Medical Examiner			sconsequence of):	CATOIO	VALS CUIA	r DR	case	
		ē	Sequentially list conditions, If any, reading to immediate	i consequence of).					
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ds,	w requires that the dispersion signed by the should be detached	þ	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.			the cause of death?
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		Com					autopsy performed 1 □ Yes 2 🗹	death?	completion of cause of 2 No
Vital	ysiclar is certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital:	nt 2 ☐ ER/Outpatien	ot 3 🗆 DOA Othe	26. Place of Death	(Check only one) ne 5 ☐ Residence	6 004 (0	
n of	Attending Physician: or death. ector: After this certifice by the funeral director, p.	On: T	27. Manner of Death 1 ► Natural 5 □ Pending (Month, Day,	y 28b. Time of	28c. Injury Work		28d. Describe how in		лгу)
DIVISION	Attend r death ctor: y the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injur	ry - At home, farm, stre		Yes 2 □No	8f. Location (Street	and Number or Ru	ural Route Number
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or inv	n occurred at the tin vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License		_	Date signed (Month	
	,_	-	20 Name and address of parameter and and and	MD		152950	1	'ugust	8, 2000
	10		30. Name and address of person who completed cause of dea Lamont C. Smith Northwest	Hospital*	·	l Court Ro	oad Randa	allstown.	MD 21133
	Stat Registra	te ar	31. Date filed (Month, Day, Year) 2008 Registrar						

			State of Marylar			alth and Me	•	$nec \cap n \cap n$	26372
		1 - For State Registrar	, ,	-	cate of De		Reg.	2000	20012
Physic	an	Decedent's Name (First, Middle, Last)	(')	/		1	2. Date of Death Month	Day Year	3. Time of Death
/Medi		Helen Dian				/	August 1	0, 2008	8:25PM
Examir	ner	4a. Facility Name (If not institution, give s	4	4b.	Baltin	*		4c. County of Death	
Funeral		5. Social Security Number 6. Sex			Inder 1 Year If		3. Date of Birth Month, Day, Ye		place (State or Foreign
Director		46-10-1001	M 25 4	7 Yrs. Mor	nths Days H		149. 10	1961 M	ary land
and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	1		-		10d. Inside City Limits
Mary 1 • ho	ţŏ	Maryland NIA	B	a Himor	e				1 Yes 2 No
th the	lrec	10e. Street and Number	1	10	f. Zip Code		10g.	Citizen of What Cou	ntry?
ath w	Funeral Director	1732 Thomas	Avenue		2/2/1			inted St	tes
ter de	-une	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	.S. 13. Was I	Decedent of Hispa specify Cuban, N	nic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White,	
5-0036 72 hours aft natural', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 25 No Si	pecify:		Specify: Bia	rek
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, uther than "naturel", or fems 23a or 28e-f show ont, tra Mexical Exacult at must be actified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's	Usual Occupation of work done during	n ng most of working	16b	. Kind of Business/In	dustry
within then then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	1 2/	15e Kze			Domestic	٠
nd 212 e filed with Il Hygiene. other the	BeC	17. Father's Name (First, Middle, Last)					First, Middle, Maid	den Sumame)	
Vian	To E	Charles Sava	ge			Povis	Brooks	5	
Nore, Maryland 21215-0036 gas 1 and 2 should be filed within 72 hours after death with the Marylar at of Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumetic event, If a Medical Exacutar traumetic event,		19a. Informant's Name/Relationship (Type)	on, Print). - Sister			A		ty or Town, State, Zip	
Te, N 1 end Heelth tem 27 other tr		20a. Method of Disposition	20b. F	Place of Disposition	Thomas (Name of	Ave,		Location - City or Te	
datimore, rmit. Pages 1 er partment of Hee portant: If item 3 y Injury or other 168.		1 DBurial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cremators cust 210	or other place)	Aug 15		Beltimore	
Baltimol permit. Pages Department of Important: If it eny Injury or o		21. Sign were if Funeral Service License	· / ·	22 Nan	ne and Address of	Facility /- C/		5 P.A.	
00 89E89		(alum 2. l	thous	2	o Fred	Philton	Pass	Balto11	10 21119
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not enter the		uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq		IIDS				years.
Examiner		Convention line and discon	500 (5) 25 2 55/1360	delice (i).					,
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68 tifficate ng phy as the									
. BOX 68 death certifica e attending ph d for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pic pregnancy			23d. Date of deliv	,
the dear	Physician/Med	1 Yes 2 No 9 Unknown	4☐Pregnant at time of d 9☐ Unknown	eath 5 ☐ Othe	r (specify)			Month	Day Year
- E 2 B	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ing cause given in	Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
VITAI MECONAS, steian: The law requires to certificate has been signe rector, page 2 should be or	ed b						1 🗆 Yes	2 No 3 Prot	pably 4 Unknown
law re law re as be	Completed						24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
	Соп						performed	? death?	
VISION OF VITAI Attending Physician: T r death. ector: After this certificet by the funeral director, pa	o Be	25. Was case referred to medical examiner?	ospital:		Other	. Place of Death			
OF Physical Colored disconnecte	l Hou	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		d. Describe how in	6 ☐Other (Special	(y)
ath. or: After	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M		2 🗆 No			
DIVISION all or Attending s after death. al Director: Afte ed in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa	ctory, office	28	f. Location (Street City or Town, St	and Number or Rura late)	al Route Number,
poltal o		29a. Certifier 1 Certifying Phys	icien: To the best of my kno	winden death con-	rod at the time of	late and place an	d d	(-)	
ne Hos ne Fur sletely	Medical	(Check only 2 Medical Exemin	er: On the basis of examina and manner stated.	tion and/or investiga	ation, in my opinio	nate and place, an on, death occurred	at the time, date	and place, and due to	tated. the cause(s)
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Ž	29b. Signature and title of certifier		,	29c. License nur		29d.	Date signed (Month,	Day, Year)
_					D	37573	A	jugust 11	15008
2		30. Name and address of person which cor	nple cause of death (Item	n 23a) (Type, Print)	st.	Qa.1	ب بر ملمرین	ogust 11	ション /
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		31	17567	10510WV	7/1/	C1136
Registr	ar	AUG 1 5 2008	Home . K	Brack 3					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Year Rita Trionfo 08 09 2008 4:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2216 Queensbury Drive Harford Fallston, Maryland If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🗓 F Yrs Director <u> 214-20-9874</u> 82 06/22/1926 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 23a 2216 Queensbury Drive 21047 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. f and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'n, 1 ☐ Yes 2X No þ Specify: White 3X Widowed 4 □ Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaking Own Home Ifth and Mental Hygier 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Anselmi ည Josephine Monti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Frank M. Trionfo, Jr. (son) 2216 Queensbury Drive - Fallston, Maryland 21047 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ō permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 08/13/2008 | Baltimore, Maryland 21. Signature of Funeral Service Licensie 22. Name and Address of Facility E. F. Lassahn Funeral Some, P.A. 11750 Belair Road - Kingsville, Maryland 21087 ap 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** BRAIN TUMOR GLIOBLASTOMA disease or condition resulting in death) MULTIFORME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examiner Due to (or as a consequence or, law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1∏ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performaco? Yes 2 (No certificate 1 □Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Marmer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008

State Registrar

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SEIN AUNG

31. Date filed (Month, Day, Year)

FRANKLIN SOUARE DRIVE # 2200, BALTIMORE MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9103

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

324Registrar's Signature

Larson

31. Date filed (Month, Day, Year) AUG 1 5 2008 08-06158 Terry Wright Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26375

			I- For State Registrar				Certifica	ate of i	Death	7			R	eg. No.			
	Physicia		Decedent's Name	(First, Middle,Las	st)							2	. Date of Dea		Voor	3	. Time of Death
•			Terry Alle	en Wriah	t.								Month August 12	Day 2008	Year	-1	1158 hrs
			4a. Facility Name (if			umber)		4t	c. City, T	own, or Lo	ocation of				unty of De	eath	
			2733 N. Calv			,			Baltim			*				N/A	
	_		5. Social Security No		ev	7 Age /In	yrs. last birt	hdav)		r 1 Year	If Under	24Hre	8. Date of Bir	th (MM/DD/	YYYYY 9.	Birtho	lace (State or
	Funeral		•			7. Age (III		nuay)	Months	4	Hours	Min.		`	Fo	reign	Baltimore.
	Director		218-56-06	22 1	M 2 F	,	58	Yrs.		. 54,5			June 1	6,195	0	Coun	tryMaryland'
			Usual Residence of	Decedent													
	any		10a. State	10b. County		10c	. City, Town	or Locatio	n								0d. Inside City Limits
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1	Maryland 28a-f show 1 at once.	용	10e. Street and Num	her					10f. Zip	Code			11	0g. Citizen	of What (Countr	y?
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5	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must he notified at once.		2755 N.Ca.	IVELU DU													
~	ms 2	Funeral	11. Marital Status		12. Was De	ecedent Eve Forces?	r in U.S.						cify Yes or No ican, etc.))- 14.	Race - Al White, et		n Indian, Black,
	death r ite	S	1 X Never Marrie	d 2 Married	1 Yes	2 X	No						, , , ,				i to
	fler Ir., o	by F	3 Widowed	4 Divorce	If Yes, Give Ye	ear		1	Yes 2	No.	specify:			Spe	ecify:	VVI	ite
	urs a ntura ami	유	15. Decedent's Ed	ucation (Specify o		ade complet		Decedent						16b. Kind	of Busine	ess/Inc	lustry
	72 ho	ę	Elementary/Secon	ndary (0-12)	College	(1-4 or 5+)		during mo	st of wor	king life. L	DO NOT U	use retire	a)				
36	thar sdics	힑	12		N/Z	A			Uner	nploy	red				Unem	pla	ved
ç	gren ther	Completed	17. Father's Name (First, Middle, Las	t)							s Name (First, Middle,			<u> </u>	7.
TC.	5 E E E		Leroy Cla								larha	ra 7	nn How	ard			
21215-0036	uld be filed within 72 hours after death wi Mental Hygiene. marked other than "natural", or items e event, the Medical Examiner must be	8	19a. Informant's Nai			(Mothe	7c) 19	h Mailing	Address				ral Route Nu		r Town. S	state. Z	Zip Code)
	ar is a sk		Mrs. Barba			•	,	_						-			
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٥	TE HE T		20a. Method of Disp	Cremation 3	Removal	from State	crema Evans	tory or oth	er pla <u>c</u> e)	ne or cerne	etery,	Augu	st 18,	1			
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F	xaminer		Immediate Cause (F		Ather	coscle	rotic	card	iova	scu1	ar d	isea	se			i	Death
			or condition resulting	ig in death)	Due to (or as	a conseque	ence of):										
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Boy 6	ath c atten or us	sic	1 Yes 2 N	lo 9 Unknow	-	gnant at time	e or death	5 Oth	er (Spe	cify)							
ă	that the death certific ined by the attending p	h			9 Olik	nown			1 1 1 1 1		in Da	-4.1	22a Did	lohanna un	oostribu	to to th	on source of death?
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	ires that signed	d b	<u> </u>										1 Ye	s 2 N	10 3	Proba	ibly 4 🗹 Unknown
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5	ysici ysici his c dire	To E	examiner? 1 ✓ Yes	2 No	Hospital: 1	Inpatient	2 ER/C	Outpatient	3 E	DOA C	Other ₄	Nursing	Home 5	Residence	e 6 🗸 (Other:	Scene
ų.	ling Ph After t		27. Manner of Deat		28a. Da	te of Injury nth, Day,Year)	28b.	Time of Ir	ijury	28c. Injury	at Work	?	28d. Describe	how injury	occurred		
5	ndin th.	io	1 X Natural	5 Pending	(MOI	ntn, Day, Year)				1 Y	es 2	No					
	Attence r death	cat	2 Accident	Investiga	28e Pl	ace of Injury	- At home, t	arm stree	t factory	office bu	ildina et	C	28f. Location	(Street and	Number	or Rura	al Route Number, City
Division of Vital Records	pital or At ours after d ceral Direct	ıtifi	3 Suicide	6 Could no determin	it be		At Home,	u	.,	, 0.1100 80			or Town,				
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	e Ho 24 l e Fu etely		29a. Certifier 1	Certifying Physi	cian: To the b	est of my kr	owledge, de	ath occur	red at the	e time, dat	e and pla	ace, and	due to the cau	ise(s) and r	nanner as	state	d.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2	Medical Examin	er:On the basi and manne	s of examin r stated.	ation and/or	ınvestigati				curred at	ure ume, dat				
	F > F 5	ž	29b. Signature and	title of certifier					29	c. License	number			29d. Da	te signed	(Mon	th, Day, Year)
			his	w	, m	5				O.C.N	И.E.			Augus	st 13, 2	800	
			30. Name and addr	one of necessity	o completed	auco of doct	h /Itom 22a1										
			30. Name and addr. Ling Li, MD	ess of person who Assistant I			n (item 23a) 111 Pe r	n Stree	t. Balti	more N	ИD 212	201					
	S Regis	tate	31. Date filed (Mont	th, Day, Year)	32.	egistrar's	Signature	Land	W)								
	- 7-V-11-		40	THE PERSON ASSESSED.	ETITA L 4	A STATE OF THE PARTY AND ADDRESS OF			_								

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day James John Woodhead, Jr. /Medical 11:15 AM August 10,2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Home Essex Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 € M 2 □ F Months Days Hours Min. 220-20-5667 Director 79 Sept. 6, 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Edgemere 1 □Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7705 Beekay Road Funeral 21219 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> WWII Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marine Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Woodhead Sr. Catherine Falkenham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Bowen Woodhead (Wife) 7705 Beekay Road Edgemere Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify Entombment Oak Lawn Cemetery 8 13-2008 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Lucia - Ruck Funeral Tome 1 unitally 21. Signature of Funeral Service Licensee Inc. 7922 Wise Avenue Dundalk Maryland 21222 23a. art1. Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death _UNG an 1091 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) the 1 Yes 2 No. 9 Unknown 9 Unknown Arter this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD. WAS ERM. 709 MALKA 31. Date filed (Month, Day, Year) sistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, 2008 Year **Physician** Joan Elizabeth Wright Aug. 11:11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 844 Copley Avenue Charles Waldorf 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🖾 F Months Days Hours 59 220-56-6900 Director 10, 1949 Washington, Apr. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it is Medical Evantiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Charles 1 X Yes 2 □ No Maryland Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 844 Copley Avenue 20602 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☒No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Lee Wright Josephine E. Lacovaro ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luther T. Wright / Husband 844 Copley Avenue, Waldorf, Maryland 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland Fort Lincoln Cemetery 08/19/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility 4739 Baltimore Ave Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Adenocarcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be exect Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? 1 \(\text{Yes} \) 2 \(\text{X} \) No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation To the Hospital or Attendir) within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 2 Medical Examiner: 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35345 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zeon, M.D., 3261 Old Washington Road, Suite 3010, Waldorf, MD 20602 F. George

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 5 2008

. Registrar's Signature

		-	1 - For amend #6 21 7 a Per Nate Registrar	Thit G882 8/	125/08 JH afficate of De	ath	Reg. No. 008	26378
	Physicia	an	1. Decedent's Name (First, Middle, Last) E WILS	201		2. Date of De Month	/ Day / Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4	b. City, Town, or Loc	eation of Death	8 / 2008 4c. County of Dea	101-1
	rje S	*	University of Muryland Med 5. Social Security Number 6. Sex 7. Age		10	Under 24 Hrs. 8. Date of Birt	Baltima	thplace (State or Foreign
3.0	Funeral Director		216-77-6111			lours Min. (Month, Da	y, Year) Co 3, 2006	Maryland
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	tion			10d. Inside City Limits
	a-f sh	Director	Maryland N/A		Baltin	nore		1 KYes 2 No
	with the a or 24		10e. Street and Number 5628 Ready Avenue		10f. Zip Code	21212	10g. Citizen of What Co	,
	death	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13. Wa		nic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)		erican Indian,
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show afte event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 [pecify:	Specify:	Black
Maryland 21215-0036	72 hou 'natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occupation nd of work done during NOT use retired)	n ng most of working	16b. Kind of Business	s/Industry
121	within iene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+	-) life. DC	NOT use retired) Infa		In	fant
p	be filed tal Hyg d other svent, j	Be C	17. Father's Name (First, Middle, Last) Earl Kevin	ı Wilson	18.	. Mother's Name (First, Middle,		
ryla	2 should be filed and Mental Hygi is marked other aumatic event, the	ဍ	-Earl Thomas 19a Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and	Number or Rural Route Numb	mah Thomas er. City or Town. State.	Zip Code)
ĭ Za	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic	l	19a Informant's Name/Relationship (Type. Print) Earl Kevin Wilson /father Earl Wilson Father	562	8 Ready Aven	ue Baltimore, Marylar		, ,
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposit cemetery, crema		Date 0.014.4109	20c. Location - City o	r Town, State
atin	mit. Pa bartmer bortant Injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Syrvine Linguise		Memorial Park Name and Address of		YVIIIusui	i iviii, ivid.
Ö	Imp any one		1 Willes	en I	Estep Brot 1300 Euta	hers Funeral Service, w Place Baltimore, M	P. A. d 21217	
	Dhusisian		23a. Part. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death. Vo not enter	denital	Heart di	rrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition a.	consequence of):	gening	Treat Off	30430	19 Months
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60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Ex	resulting in death) Last Due to (or as a	consequence of):				
68760,	tificate g phys as the	ledical	d		700			
Вох	eath cer attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome p	2 ☐ Fetal death 3 ☐ E	ctopic pregnancy		23d. Date of de Month	elivery Day Year
P.O.	t the de by the a ached t	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ume or death 5 L	Other (specify)			
JS, F	w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Other significant conditions contributing to death but $RESPTRATOKY$	it not resulting in the und	erlying cause given in		tobacco use contribute Yes 2 ⊉ No 3⊟ l	to the cause of death? Probably 4 □Unknown
Division or Vital Records,	w requi	Completed	AWOXTI BRATIL	1 +11	JURY	24a. Was		autopsy findings available o completion of cause of
l Re	The la ate has page 2	Somp			(auto perfi 1 Yes	ormed death	o completion of cause of es 2 No
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatier	nt 2 ☐ ER/Outpatient	Other	6. Place of Death (Check only		
100	ng Phy ter this neral di	n: To	27. Manner of Death 1 Death 28a. Date of Injury 1 Death (Month, Day)	y 28b. Time of	28c. Injury at Work?	4 Nursing Home 5 Res	how injury occurred	весну)
Sio	ttendir death. ctor: Ay	icatic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injure	ery - At home, farm, stree		28f Location	Street and Number or I	Rural Route Number.
Δ	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, tely filled in by the funeral director.	Certification:	4 ☐ Homicide determined building, etc	: (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or To	wn, State)	,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of and manner state.	examination and/or inve				
	To the To the compl	Me	29b. Signature and title of certifier	ma	29c. License nu	umber	29d. Date signed (Mo	nth, Day, Year)
	, RP		Tasu Monamed	111D	P21	108/	8/8/2	1008
	-		30. Name and address of person who completed cause of de 22 SOUTH GREE	WE . B	BALTI	MOXE MO	2120	1, Fasil Monomed
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registra	ar's Signature	8.0			,

State of Maryland / Department of Health and Mental Hygiene 26379 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2008 Wein MAN **AUGUST** 10:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FUTURE CARE -CANTON BALTIMORE If Under 1 Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min. Director 081-07**-**0487 93 06/01/1915 NY Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites must be notified at once. 1X Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 ELLWOOD AVENUE 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 💢 No If Yes, Give Year or Dates: Specify: WHITE 2 3 M Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** LOCAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PRESSMAN ပ္ ABE TDA PRESSMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD WEINMAN / SON 10 E. LEE STREET, #702, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WELLWOOD CEMETERY 08/14/2008 PINELAWN, NY 4 Donation 5 Dother (Specify) 21. Sign rure Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Day to (or as a some equance of) physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl use a IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier 29d, Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R Bo MB 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 5 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Howard Burnside Armstrong 2008 0530 A M 8 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Union Hospital Cecil E1kton 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F Director JAN 10, 1930 212-26-5823 78 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 313 West Main Street 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1051 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Armstrong Florence Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lillian Armstrong/Wife 313 West Main Street, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition August 13. 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once, 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cherry Hill, MD 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licenses 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due Io (or as a consequence of): disease or condition resulting in death) /Medical Examiner Anen Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (pr as a consequence of): attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by en shere Vasular 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Nichne 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was colle referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral dire ۲ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation in my product the cause of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Se 312 Elkton 31. Date filed (Month, Day, Year) S Hest 2. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

AUG 1 5 2008

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month 0637 Lem Lemuels Acosta 2008 Auq. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #202 7. Age (In yrs. last birthday) 3721 Donnell Dr. Forestville Md Prince Georges

9. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1√ M 2 □ F Director 2/10/77 Honduras Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 1 XYes 2 No Director Md. PG Forestville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3721 Donnell Drive #202 Funeral 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Hispanic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Staples 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pablo Acosta Sandra Guerrero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6618 Victoria Avenue
Dallas TX 75209

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type. Print) Sandra Guerrero/mother 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 8/8/08 | Waldorf, Md. 21. Signature of Funeral Service Licensee)22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hanging /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Director: After this certific lin by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred # 5 Pending investigation 1 Natural himself quit 3, 1008 1 ☐ Yes 2.☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 37 1/ Donn 28 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide bonce To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 22-Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 1 5 2008 Registrar

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36 in 72 hours after han "natural", c	<u>}</u>	Widowed 5. Decedent's E Elementary/Sec	ducation (Spe				16a. Deceder during m	nt's Usual Occions of working	upation (Give kg life, DO NOT u	Gene	ral	16b. Kind of	e Gov	/Industry	ent
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f. sho injury or other traumatic event, the Medical Examiner must be notified at once.	. 20	Donation	sposition X Cremation 5 Other	on 3 R	elle /	State 200.	Place of Dispo	sition (Name ther place)	o Com	8-1	_3 - 08	Tows	son,	Maryla	2.0
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Box 68760, e death certificate be executed the attending physician and red for use as the burial - transit	<u>_</u> =	X UNPENDI IF FEMALE: 23b. Was deceded past 12 mor	ent pregnant i	n the	23c. If yes, ou	tcome of pr	regnancy 2	, g882 Fetal death Other (Spec		8 TT	ncy		Date of del	ivery Day	Year
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Vital Recor systeian: The law in this certificate has be director, page 2 sh	Com	25. Was case r	eferred to me	dical					26.Place of Dea		only one)	S 2 No		Yes Other: Scen	
Division of Vital Records, tal or Attending Physician: The law requings after death. After this certificate has been so the rine, the fumeral director, page 2 should the fumeral director, page 2 should the control of the fumeral director, page 2 should the control of the fumeral director, page 2 should the control of the fumeral director, page 2 should the control of the fumeral director, page 2 should the control of the c		examiner? 1 Yes 27. Manner of I X Natura		Hos Pending	28a. Date o	of Injury Day, Year)	ER/Outpa		28c. Injury at W	ork?	1	be how injur	у осситес		
Division To the Hospital or Attend within 24 hours after death. Fro the Funeral Director:	Certification:	2 Accide 3 Suicide	e 6	Investigation Could not be determined	(Specify)				y, office building		or Tow	n, State)			ute Number, Cit
To the Hospite within 24 hour To the Funers	Medical Ce	4 Homic 29a. Certifier (Check only one)	Certifyi Medica	Examiner:	n: To the bes On the basis of	of examinat	wledge, death ion and/or inve	stigation, iii ii	e time, date and ny opinion, death		d due to the o at the time, o			e to the cau	se(s)
To the within.	Med	29b. Signature	and title of c		and marrier o			25	O.C.M.E.	ber		1	ust 11,		
		30. Name and	address of p	erson who co Assistan	t Medical I	Examine	r 111 Pe	nn Street,	Baltimore, I	MD 2120	01				
Reg	State istra		(Month, Day,	1 5 2l	008 ^{32. F}	distrar's S	, 0.	Goods	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day BEARQ **Physician** 9:201 EdWARd 25 AWRENCE 2008 JUL /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner VAMEDICAL ALTIMORE SALT MORE enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 57 Yrs. **Funeral** 1 M 2 □ F Months Days Director 234-80-6265 JULY 20,±1951 PETERSBURG WV Usual Residence of Decedent 10b. County GRANT 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No PETERSBURG Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number HC 59 BOX 51 26847 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CAR SALES AUTO SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN SEIGFRED BEARD, JR. HARRIET CAROLINE BRINKMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 SEQUSIA DR. LEWISVILLE, NC CLARA COTTRELL DAUGHTER 27023 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If iter any injury or oth WVU HUMAN GIFT 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 07/26/08 MORGANTOWN, WV 22. Name and Address of Facility WVU HUMAN GIFT REGISTRY, P.O. BOX 9131 morGANTOWN 26506 21. Signature of Funeral Service License 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final thes **Physician** MONAR disease or condition resulting in death) /Medical Examine ROLOGENI Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Inpatient 28a. Date of Injury 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day

The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760. ed by the a signed I Division or Vital Records, page 2 s certificate this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of or Attending

is 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene the Path and Mental Hygiene then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide

determined 4 ☐ Homicide 29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific

30. Name a daddress of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREEFESTREET BALLMORE, MD 2201

and manner stated

31. Date filed (Month, Day, Year,

AUG 15

🍘 Registrar's Signature

DHMH 17 Rev 1/2001

To the Hospital

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of r	viaryiani	Cei	artment of r tificate of	neaith and i Death	vientai Hy	giene Reg. No. 20 (8 (26384
н	Physici	an.	1. Decedent's Name (First, Midd	fle, Last)					2. Date of De Month		ear	3. Time of Death
2 4	/Medic		Beth	L.		H	Bugas		July 2	28 2008		12:15 P M
	Examin	ier	4a. Facility Name (If not institution Wicomico Nursing H		er)		4b. City, Town, o	or Location of Death ury	n	4c. County of Wicomi		
	Funeral		5. Social Security Number		Age (In yrs. I	* * * * * * * * * * * * * * * * * * * *	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th (Birthpl	ace (State or Foreign try)
ш	Director		521-34-2749	1□M 2∏F	83	3 Yrs.			2-9-19		Jyom	
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	r 28a	irec	10e. Street and Number	III CO	Sal	isbury	10f. Zip Code			10g. Citizen of Wh	at Coun	try?
	th with	a D	1514 Riverside	Drive			218	01		USA		
	ems ems	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No to Rican, etc.)	14. Race -	America White, e	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Ma 3 🌠 Widowed 4 ☐ Divorce	rried 1 Yes 21	Ž] No		1 □ Yes 2 No		,	Specify:		ite
21215-0036	2 hou	Completed by	15. Decede	nt's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of Busi	ness/Ind	lustry
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	filed within I Hygiene. other than ent, the M	S	12	4		Tel	ler			Bank		
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2	2 should be f and Mental H Is marked of raumatic eve	မ	Carl 19a, Informant's Name/Relation		autch	10h Bitolli	na Adduna (Otroni	Mabel	unal Claude Alicente	Bernar		
Ma	d 2 sl th an 7 is r traur		Pete Bugas - N			1				er, City or Town, Si		Code)
	Health tem 27 l	1 3	20a. Method of Disposition	ephew	20b. P	lace of Dispo	sition (Name of	1	Alisbury Date	MD 2180	ty or To	wn, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (ite		matory or other pla of Do 1 m	arva: 8–1	2000	D = 1	D 1	
altii	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service		21					Delmar, neral Hom	ье пета	aware
Ö	permi Depar Impor any ir		11/11/1550	Herry 19	Valo					ury. MD 2		/,
	= 1		23a. Part. Enter the disease, shock, or heart failure. Lis	or complication that caused only one can see on each	sed the death	n. Do not en	er the mode of dy	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
-	Physician	(S. 7)	Immediate Cause (Final disease or condition	10/1				VASOULA	_		- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	11000		9. 92/0	1.C.I.S.C.	- 7	
86	LAUMMICI	<u>.</u>	Sequentially list conditions,	b. — Due to (or	as a consequ	ionoo of):					-	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	State to (or	as a consequ	derice or).						
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Вох	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me pf pregna n 2 □ Fetal		∃Ectopic pregnanc	ev		23d. Date		,
.O. E	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the bunal-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		t at time of de		Other (specify)	,	·	Mont	h	Day Year
<u>α</u>	that the de led by the a detached f	Ph	Part II. Other significant condi	tions contributing to deat	h but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	tobacco use contrib	ute to th	ne cause of death?
Records,	uires than signed Id be det	Completed by	SEIZULF	DISORDER		3	, , ,			Yes 2 No 3		
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Re	The law	dmo	7114614177						auto perfo	psy pri ormed? de	or to cor ath?	npletion of cause of
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Ž	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 🗌	ER/Outpatie	nt 3□ DOA Ot	hor:		idence 6 □Other	(Specifi	v)
n or			27. Manner of Death Natural 5 ☐ Pend	28a. Date of (Month,	njury Day Year)	28b. Time o Injury	f 28c. Inju			how injury occurred	· · · · ·	
Sio		satic	2 ☐ Accident inves	tigation				Yes 2 No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director Afte completely filled in by the fune	Certification:	3 Suicide 6 Coule 4 Homicide deter	minod Zoe. Place of	injury - At ho , etc. <i>(Specif</i>)	ome, farm, st y)	reet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rura	l Route Number,
	spital ours seral filled		29a. Certifier 1/ Certify	ring Physician: To the be	est of my kno	wledne deal	h occurred at the t	ime date and place	e and due to the	cause(s) and man	nor ac ci	tated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medic	al Examiner: On the basi and manner	s of examina	tion and/or ir	vestigation, in my	opinion, death occ	urred at the time	, date and place, ar	d due to	the cause(s)
	To th withir To th	Me	29b. Signature and title of certif	ier			29c. Licen	se number		29d. Date signed	Month,	Day, Year)
			VVIIIA.	SunT	- 0	110	0	60515	-	7/22/	12	
-	181		30. Name and address of person	n who completed cause of	of death (Item	23a) (Type,	Print)	3-1)	-	100/	, O	
	. 000	0. 1	Mahesha Thimmaray		_		or., Salisb	ury, MD 218	804			
3.1	Sta Registi		31. Date filed (Month, Day, Yea		istrar's Signa	B 1	mell					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 31, 2ď08 JÜĽY 8:35 A M THEODOSIA WALL BRYANT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES FORT WASHINGTON HOSPITAL FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days Min. 1 □ M 2 👿 F Months 96 MARCH 20,1912 NORTH CAROLINA 121-18-2319 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at 28a-f show 1X Yes 2 □ No Director FORT WASHINGTON MARYLAND PRINCE GEORGES 10e. Street and Number 10g. Citizen of What Country? 20744 UNITED STATES 9807 OLD ALLENTOWN ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 6TH GRADE College (1-4or 5+) GARMENT FACTORY FACTORY WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Item 27 is marked or r other traumatic eve permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev RIDA BEALE WALL WILLIAM WALL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 THEODOSIA GRIFFIN / DAUGHTER 9807 OLD ALLENTOWN ROAD, FORT WASHINGTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State BRYANT FAMILY CEMETERY AUGUST 6,2008 RICH SQUARE, NORTH CAROLINA 4 Donation 5 Dother (Specify) Separative of Furneral Service Licensee

ANDIA C. THORNTON JOHNSON MO0583 22. Name and Address of Facility
THORNTON FUNERAL HOME, P. A
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

messali 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2000

(Check only one)

AUG 0 1 2008

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

11 >11 Find Syon Pagistrar's Signature

State

Registrar

29c. License number

0-57

D0054723

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 8:35 PM Isaac R. Boyd August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 389 Ridge Road Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs 1**☑** M 2□ F Months Hours Director May 2, 1920 Maryland 218-14-0251 88 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a State 10h County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 1 No Director Maryland Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 389 Ridge Road 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. δ 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Agriculture Farmer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked Burton M. Boyd Charlotte A. VanDyke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If Item 27 is any injury or other trau 260 Hendrickson Lane, West Grove, PA 19390 John Boyd/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-6-2008 Hopewell Cemetery Port Deposit, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. S. Queen Street, Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lailure /Medical Due to (or as a lon equence of): Examiner Due to (or as i) onsequence of) atrie YEAT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner -transit certificate be executed and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9∏Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate I 1□ Yes 2 1 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: ospital or Attending hours a er dea h. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours a To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) DOC44373 2008 ss of person who competed of use of death (Item 23a) (Type, Print) 30. Name and ad Joseph K. Weidner, Jr., M.D. 101 Colonial Way, Suite A, Rising Sun, MD 21911 31. Date filed (Month, Day, Year) State **AUG** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26 per Phys 7/31/08 CCHD DBCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ju 10 28, 2008 **Physician** 5:30 Cabell Pierce Bragg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mechanicsville St. Mary's 40335 Beach Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 04/03/1913) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 X M 2 □ F West Virginia 214-14-1974 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State "naturai", or items 23a or 28a-f show edicai Examîner must be notified at 1 ☐ Yes 2√ No Director St. Mary's Mechanicsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20659 U.S.A. 40335 Beach Drive within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rhoda E. Cox James Jackson Bragg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40335 Beach Drive, Mechanicsville, MD 20659 Franklin P. Bragg/ Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 08/02/2008 | Baden, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd., Waldorf, MD 20601 M01436 23a, Part1, Pnter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Stage End **Physician** /Medical Due to (or as a conse dence of): Examiner Sequentially list conditions, if any leading limit of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s performed 2 □ No 1 TYes 2 200 ours efter death.

neral Director: After this certific:
filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 4 Nursing Home 5 X Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? Injury (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: 24 hours e To the Hosp within 24 hou To the Fune completely fi

Medical State Registrar

30. Name and address of pers

29c. License number H0055751 29d. Date signed (Month, Day, Year)

se of death (Item 23a) (Type, Print)

Merchants Lane Leonardtown M. 0900

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier

JUL 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19b, perFH, G882, 8/19/08, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 15 PM Betty Brown 2008 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 💢 F 578-38-9840 77 1930 Sep. 18, Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Crofton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1798 Sharwood Place 21114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: 3XXWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada M. Yarbrough William G. Cone 19 Najling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 613 Kinderbrook Lane Bowie, MD 20715 Kelly Campion/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 7/30/2008 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OP exacerbatto disease or condition resulting in death) 24 hrs Due to (or as a consequence of): QI Sequentially rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 28 No 2 No 1 TYes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 Accident М 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

or Attending Physician: The law requires that the death certificate be executed physician a s the burial-Box 68760. attending p P.0. ed by the a detached f s been signed be should be deta Division of Vital Records, this funeral After

Physician

/Medical

Examiner

10a. State

Funeral

Director

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and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any Injury or other trau

Physician

/Medical

Examiner

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the Medical Examiner must be notified at

Directo

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

page 2 s

director,

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: pletely filled in by the To the Hospital

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, JUL 3 0 2008

Medica

Year)

30. Name and address of person who completed

29b. Signature and title of certifier

200



ause of death (Item 23a) (Type, Print)

and manner stated

ORIGINAL.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 3. Time of Death O 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200° \$ Physician Joanna Month Day Cato 810 30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** comico oastal Hospice at Th If Under 1 Year 8. Date of Birth (Month, Day, Year) 11/28/1916 Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2 🕱 F 218-34-9849 91 Director Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Exminer must be notified at Director Maryland Wicomico Salisbury 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1109 S. Schumaker Dr., Apt. 212 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If them 27 Is marked others any Injury or other 27. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 INo Specify Specify: Completed by 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis C. Hauk Una Parmelley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Hansen/daughter 2067 Tarry Town Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 8/4/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
HOIloway Funeral Home Professional Association 16th 1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** CRREBROLASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner frany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death 9□Unknown Month Dav Year 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2∰Ño 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy ce tificate 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 25 No Other: 4 Nursing Home 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/ Natural 5 Pending investigation 1 TYes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2052416 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1733 SALISBURY IND 21802 WARKS HOSTICR COASTAL State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician FRANK** BILLY **COOPER** 0429 /Medical 3/ 14/4 2008 Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Jalisbury Medical Center WICOMICO If Under 1 Year | If Under 24 Hrs Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Hours Min 224-52-5690 Director 08/04/1936 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Exactings must be notified at 10d. Inside City Limits Director **ACCOMACK** 1XYes 2 No **TANGIER** VIRGINIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 5049 CANTON ROAD Funeral 23440 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces:

1 MYes 2 No
If Yes, Give
Year or Dates J.S. NAVY 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò þ 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Specify: A-IIF "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 9 TOWN other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental 27 is marked traumatic e JOHN **COOPER** ပ ADDIE (UNKNOWN) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a REV. DR. ROBERT E. COOPER SON 2609 PAMLICO LOOP, VIRGINIA BEACH, VIRGINIA permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other Injury or other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW TESTAMENT CEMETERY 08/02/08 TANGIER, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAMS FUNERAL HOME 125046 PARKSLEY ROAD, PARKSLEY, VIRGINIA 23421 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cars. Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 → Onknown has 2 S 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate ha autopsy performed? 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ After this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

State Registrar

EP)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2 Date of Death Month 7/27/2008 **Physician** Ariel R. Chedester 1849 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 □ M 2 12 M 88 3/19/19/20 476-03-4823 North Dakota Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprinret must be notified at once. Director MD 1 ∏Yes 2X No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 157 Williams Dr. 21401 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify White þ Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gov Accounting Office US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Reidy Agnes Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Chedester Spouse 157 Williams Dr. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 7/29/2008 | Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final hysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VInari Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Dav Year 5 ☐ Other (specify) □Yes 2 No P.0. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 es 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy perform certificate 1 □ Yes 2/200 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 7. Registrar's Signature State JUL 3 0 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2008 26392

		1- For State Registrar			,	Ce	ertifica	ate of	Death			, ,	Re	g. No.		
Physicia	an/	1. Decedent's Nan	ne (First, Midd	le,Last)								2	Date of Deat	h	Year	3. Time of Death
al Exami	ner					an Lentz	z Cowa						August 8,	2008		0615 hrs
		4a. Facility Name Howard Co				imber)		4	o. City, To Colum		ocation of	Death		Howa	nty of Death	
Funeral		5. Social Security		6. Sex	spital	7. Age (In yrs	last hirth	nday)	If Under		If Under	24Hrs	8 Date of Bird			holace (State or
Director							L 6		Months		Hours	Min.	10/0	3/1991		hplace (State or n District of untry) Columbia
		217-33- Usual Residence		1 <u>X</u> M	2F			Yrs.				<u> </u>	10/0	3/1331		muy) Columbia
any	1	10a. State	10b. County			10c. Ci	ty, Town o	or Locatio	on							10d. Inside City Limits
	<u>_</u>	Maryland	н	oward						Colu	mbia					1 Yes 2 X No
faryla	Director	10e. Street and No	umber						10f. Zip (10	og. Citizen o	f What Coun	try?
ith the Maryland 23a or 28a-f show a notified at once.		6424 N	Misty To	n Pass	S						2104	4			U.S.	Α.
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once.	Funeral	11. Marital Status		1		edent Ever in	U.S.		Deceden		anic Origi	in? (Spec	cify Yes or No			can Indian, Black,
or ite	اج	1 X Never Marr	_	larried	1 Yes	2 X No						ruello K	ican, etc.)	ľ	Vhite, etc.	
s after ral",	b	3 Widowed		0	Yes, Give Year Dates:				Yes 2					Spec	y.	casian
hour "natu	ted	15. Decedent's E Elementary/Sec			College (1				s Usual C st of work					16b. Kind o	f Business/I	ndustry
36 Thin 72 than	ompleted	1		1	College (1-4-01-01)				Stud	dent				Fd	ucation
5-00 led with Hygien other	Con	17. Father's Name		, Last)								s Name (F	First, Middle, N	l /laiden Surna		deacton
21215-0036 uld be filed within 72 hours afte Mental Hyggiene. marked other than "natural", e event, the Medical Examiner	Be		E11i	ott Co	owan							Sa	11y Ann	Lentz		
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e, MD I and 2 sh Health and item 27 is			tt Cowan	- Fat	ther								ia, Mar			
F 2 2 = 5		20a. Method of Di		n 3	Removal fr		b. Place of cremato	f Disposit ory or oth		e of ceme	etery,		Date	20c. Locat	ion - City or	Town, State
Page ment fant: or otl			5 Other S	pecify:			Columb	ia Me	moria.	l Parl	c	08/1	0/2008	Colu	mbia, M	aryland
Baltimore permit. Pages 1 g Department of H Important: If it injury or other t	П	21. Signature of F	uneral Service	License	e Carrie	0.0		Hin	es-Ri	Address c n aldi	f Facility Fune 1	ral Ho	me, Inc			
	-1	23a. Part I. Enter t	the disease	complica	ations that o	aused the dea	eth Do no									ryland 20904 Approximate Interval
ີ hysician Medical		failure. List o	nly one caus	n each	line.		aut. Do no	t criter tri	c mode o	r dynng, si	ucii as ce	ardiac or i	copilatory arr	sst, snock, o	Healt	Between Onset and Death
Examiner		Immediate Cause or condition result		_		ditis	e of):									Death
		Sequentially list c	onditions	b.			3 01).									
	ner	if any, leading to i	mmediate		e to (or as a	consequence	e of):									
	Examiner	(Disease or injury events resulting in	that initiated	c	e to (or as a	consequence	e of):			_						-
outed nd transit				d												
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Medical	X UNPENDE	D		AMENDED	23a,27	,per	ME,	g883	, 9/4	4/08	TT	-			
ficate be exe g physician at the burial -	/Me	IF FEMALE: 23b. Was deceden	at precipant in	be		outcome of pre	egnancy	_						23d. Da	te of delivery	,
30x 687 death certifi te attending I for use as t	ian	past 12 month		ile	1 Live b	oirth nant at time of	death -				Ectopic	pregnand	су	Mon	th [Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2	No 9 Ur	known	9 Unkn		death 5	Oth	er (Spec	ту)						
that the detached		Part II. Other sign	nificant condi	tions co	ontributing to	o death but no	t resulting	in the ur	nderlying	cause giv	en in Pa	rt I.	23e. Did to	obacco use d	contribute to	the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	d by												1 Yes	2 🗸 No	3 Prob	pably 4 Unknown
Records, The law require ficate has been si , page 2 should b	Completed												24a. Was			topsy findings available completion of cause of
ecc he lav ite has	Ĕ						-		-	-				rmed?	death?	
tal Rec isan: The certificate ector, page		25. Was case refe	erred to medic	al					2	6.Place o	of Death (Check or		2	1 10	2
Division of Vital I tal or Attending Physician: rs after death. In Director: After this certification by the funeral director.	o Be	examiner? 1 ✓ Yes	2 No	Hos	pital: 1	Inpatient 2	✓ ER/O	utpatient	3 DO	DA O	ther4	Nursing	Home 5	Residence	6 Other	:
I of Ing Pt After Uneral	Ë	27. Manner of Dea	ath		28a. Date (Month	of Injury	28b. 1	Time of In	jury 2	8c. Injury	at Work	? 2	8d. Describe	how injury o	ccurred	·· -
ion ttend death.	읉	1 X Natural 2 Accident		ding estigation						1Ye	s 2	No				
ivision or Attene after death Director:	Certification:	3 Suicide	6 Cou	ld not be	28e. Plac	e of Injury - At	t home, fa	rm, stree	t, factory,	office bui	ilding, etc	c. 2	8f. Location (umber or Ru	ral Route Number, City
Div Hospital or 24 hours afte Funeral Di	è	4 Homicide	dete	rmined	(Specify)								-	,		
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		29a. Certifier (Check only one)		-		st of my knowle of examination	-									
To the To the Complet	Medical	29b. Signature an		at	nd manner s			osugati		License		-5.104 at 1	une, date			nth, Day, Year)
			_0	0	(A)				1200	O.C.M				1	8, 2008	, Day, 10ai/
		30. Name and add	tress of perso	who cor	moleted com	se of death /#-	em 23a)			_ , _ , , , , ,						
ļ		Laron Lock				al Examine	,	Penn	Street,	Baltim	ore, MI	D 2120	1			
St	ate	31. Date filed (Ma	nti Day Year	200	32.4	egistrar's Sign	ature	A.a.	ME a							
Regist	rar	A	OU TY	200	U	Messer.	Nr.									

OCME

within To the

State

29b. Signature and title of certifier

5851 -

Registrar

Road

29c. License number

D 50653

Gyan. c. Surona

Deale

29d. Date signed (Month, Day, Year)

2008

and manner stated

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2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

Surona.

Church ton

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** Month Mayton 7:45 AM July 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis HealthCare -The Pines Talbot Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2□ F Months Days Hours 219-62-9744 July 10, 1955 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Funeral Director MD Talbot aston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 Higgins ZL SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural"; or ite Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ò 3 ☐ Widowed 4 ☐ Divorced Black Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pierce SiR, 2 Clayton .dvs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25575 Auction Rd. Federalsburg, MD, 216
Date 20c. Located - City or Town, State Marvin Lee ierce MD, 21632 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I-Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/08 Richards Nem. Park Easton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. 510 washington St. Cambridge, MD. 21613 nelle 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such all cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia weeks /Medical Due to (or as a consequence of) Examiner phagia with weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 610 CHMANS ROWLLY State

DHMH 17 Rev 1/2001

Registrar

Clayton

08-05842 James Diggs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 26395

		- For State Registrar				Ce	ertifica	te of	Death					leg. No.	20		002
Physicia dical Examin	n/	1. Decedent's Name JAMES DI		le,Last)									Date of Dea Month July 30, 2	Day	Year	3. Time of Deat	th
		4a. Facility Name (if		_	reet and nur	mber)		4	c. City, Tow La Plata		ocation of	Death		4c. Cou Char	inty of Deat les	,th	
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In yrs	. last birth	day)	If Under		If Under	_	8. Date of B	irth(MM/DD/Y	(YYY) 9. Bi Forei	irthplace (State or	
Director		215-26-0	443	1 X M	2 F	78		Yrs.	Months	Days	Hours	Min.	OCTOBE	R 31, 19	929 6	ountry) MARYL	AND
	-	Usual Residence of				Lie		1								10d. Inside Cit	v i imits
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or items	Funeral	Never Marrie	ed 2 X	Married	Armed Fo			If Ye	es, specify (Cuban,	Mexican, I	Puerto Ri	ican, etc.)	,	White, etc.		
fler de		3 Widowed	4 Di	vorced If	Yes, Give Yea	1950-19		1	Yes 2 X	No	specify:		_	Spe	cify:BLAC	K .	
2 hours aft "natural" I Examine	d by	15. Decedent's Ed	ducation (Sp		highest grad				's Usual Od					16b. Kind	of Business	s/Industry	,
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5-0036 led within 7 Hygiene. I other than	Ē	17. Father's Name	(First Middle	e. Last)				ши	TILLIN		8. Mother's	s Name (F	First, Middle	, Maiden Suri		OALMARIA	
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212 ould b d Men s mar	리	19a. Informant's Na	ame/Relation				ł i	_								ite, Zip Code)	
MD 2 sho alth and m 27 is sum at i		MAURICE T.		/ NEPT	IEW .	Lao			HLAND .				MARYLA Date	AND 200		or Town, State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once or other transmatic event, the Medical Examiner		20a. Method of Dis		on 3	Removal fr	om State	cremato	ory or oth	ner place)						Í		
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5				IMA	ARYLAN							DB CHELL	ENHAM,	MARYLAND	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med		LYDIA C. T				0583		1110	ame and A	FUNE	RAL HC	ME, F	P.A.	FAD. MAR	WT AND	20640	
Physician	-	23a. Part I. Enter th	he disease, o	or complica	ations that c		ath. Do no	t enter th	ne mode of	dying, s	such as ca	ardiac or i	respiratory a	rrest, shock,	or heart	Approximate Between Or	
/Medical		failure. List or Immediate Cause	•	ш,		ve Atheros	sclerotic	: Cardi	ovascula	ar Dise	ease					Deat	
-xaminer		or condition resulti				consequenc											
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uted id ansit	Examine	events resulting in			ie to (or as a	a consequenc	e of):										
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lox 687 leath certific e attending I	cian	past 12 month			1 Live	nant at time o	of death 5	- 1	tal death her <i>(Speci</i>		Lotopic	program	,	""			
Box 68 re death certi the attendin	Physicia	1 Yes 2	No 9 U	nknown	g Unkr								100 0			1- 11	la ath O
P.O.	by P	Part II. Other sign	nificant cond	titions c	ontributing t	to death but n	ot resulting	g in the u	underlying (cause g	iven in Pa	art I.				to the cause of d Probably 4 🗸 U	
v requires that s been signed by should be deta	ed k												24a. Wa			autopsy findings	
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of Vital Records, ag Physician: The law requiranter this certificate has been sineral director, page 2 should be	ပ	1 Yes 27. Manner of Dea	2 No		<u>'</u>	Inpatient 2 e of Injury		Time of		70	ry at Work			ne how injury		1101.	
on of nding Pt th. r: After re funeral	Certification:	1 V Natural		ending	(Mont	th, Day, Year)				1_1	res 2	No					
Division tal or Attendir rs after death. all Director:	ficat	2 Accident 3 Suicide		vestigation ould not be	28e Pla	ce of Injury -	At home, fa	arm, stre	et, factory,	office b	uilding, et	tc.			Number or	Rural Route Num	nber, City
Division ospital or Attend hours after death neeral Director;	erti	3 Suicide 4 Homicide	de	termined	(Specify)							or rowr	n, State)			
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.		29a. Certifier (Check only one)	Certifying	Physicia	n; To the be	est of my knov	vledge, de on and/or i	ath occu	rred at the	time, da	ate and pla	ace, and	due to the ca	ause(s) and r ate and place	manner as s	stated. o the cause(s)	
To d comp	Medical	29b. Signature an		ε	and manner	stated.					e number		_			(Month, Day, Year))
	-	1	asher	5	ee	no				O.C.	M.E.			July 3	31, 2008		
		30. Name and add	dress of pers	on who co			(Item 23a)										
DB4=1		Tasha Gre	enberg M	D. A		Medical Ex		111	Penn S	treet,	Baltimo	ore, MD	21201				
S	tate				32. F	gistrar's Sig	nature	1	ale								
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DHMH 17 Rev 1/2001 OCME 2006

Physi /Med Exam

Funera Directo

	Please Type or Prin							_		
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	Decedent's Name (First, Middle, Last)					2. Date of De	ath	200	3. Time of Dea	ath
an al	GLENDA LOIS DALY					JULY	30	ay Year 2008	12:04 E	РМ
er	4a. Facility Name (If not institution, give street and number) Brooke Grove Rehabilitation	n Center		b. City, Town, or Sandy	Spring		40	C. County of Deat	h	
	5. Social Security Number 6. Sex 1	(In yrs. last birth		f Under 1 Year Ionths Days	Hours Mir		y, Year	9. Birt Co L957 Ma	hplace (State or Fo untry) aryland	reign
ctor	10a. State 10b. County Md. Montgomery	10c. City, Town		ion	·				10d. Inside City Li 1 □ Yes 2	
Funeral Director	19132 Bloomfield Road			10f. Zip Code	20832			itizen of What Co United S	•	
by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			s Decedent of His es, specify Cubar Yes 2 No	spanic Orlgin? (n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.))-	14. Race - Ame Black, White Specify:		
Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	(Give kind life. DO	t's Usual Occupa d of work done do NOT use retired)	uring most of w	orking		Kind of Business/	•	
S	121	S	ecur	ity Supe					ontractor	
Be	17. Father's Name (First, Middle, Last)				18. Mother's Na Marqa	ame <i>(First, Middle</i>			enze	
ပ္	Warren Glynn Wessells 19a. Informant's Name/Relationship (Type. Print) Patricia Lee Jarboe / Siste				nd Number or I	Rural Route Numb	er, City	or Town, State, 2	Zip Code)	
						Date				
	20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		uls	on (Name of ory or other place Cemetery	7 8,	/4/08		Location - City or		
	21. Signature of Funeral Service Licensee Murief H. Burker	_	M		, Barbe:	r Funera , Laytons			20882	
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e.	My f): Luk	ELOM					Approximate Interval Between Onset and Deat 3 YEA	th MS
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown 23c. If yes, outcome of the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown	2 🗌 Fetal death		ctopic pregnancy ther (specify)				23d. Date of del Month	ivery Day Year	r
d by Pt	Part II. Other significant conditions contributing to death bu	t not resulting in	the under	rlying cause give	n in Part I.				the cause of death	
Complete						24a. Was auto perfo		prior to death?	utopsy findings avail completion of cause	lable e of
Be (25. Was case referred to medical examiner?					eath (Check only	one)		75	
	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatier 27. Manper of Death 28a. Date of Injur	nt 2 ER/Out	<u>'</u>	3 DOA Othe	4 🖺 Nursing	Home 5 Resi			cify)	
Certification: To	1 Natural 5 Pending (Month, Day 2 Accident investigation	(Year) In	ijury		es 2 □ No	28d. Describe				
I Certif	4 Homicide determined 28e. Place of inju-	(Specify)				City or To	wn, Sta	te)	ural Route Number,	
Medical	29a. Certifier (Check only one) 2□ Medical Examiner: On the best of and manner star	examination and ted.	d/or invest	tigation, in my op	inion, death oc	ce, and due to the curred at the time,	date a	nd place, and due	to the cause(s)	
2	I Note to Children	TENDIN YSI CLA		29c. License		(M)	29d. D	ate signed (Mont	h, Day, Year)	5
	30. Name and address of person who completed cause of de ROBERT FIELDS M.D.	eath (Item 23a) (1			HILIP	PR 0	LN	EY, MI	2083	32

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Joan Carolyn Davis 2008 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOM CASTAL DALISBUR 100 DICE HOS LAKE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days Hours Min. 1□M 2XF 65 Feb. 10,1943 Maryland 213-42-3130 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 602 Ardmore Terrace 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify. White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Marie Rauh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Davis/Son 5967 Route 14, East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 7/31/2008 5 Other (Specify) Delmar, Delaware 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signature of Funeral Service that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. Part . Enter the disease, or complications speck, or heart failure. List only one eaus Immediate Cause (Final disease or condition resulting in death) PULMONARY OBSTRUCTIVE CHRONIC DRSBAS Due to (or as a consequence of): Em BOLISM ULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 25 6 ☐Other (Specify) jury occurred

Physician /Medical Examiner Examiner

permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nat any Injury or other traumatic event, the Medica

Maryland

Baltimore,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

Director

Completed by Funeral

Be

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requires that the death certificate be executed burial-trai for use signed t page 2 Physician: funeral director this Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

Completed by

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at time of de 9□Unknown	eath 5 ☐ Oth	her (s	specify)		-	
rt II. Other significant condition	s cont	ributing to death but not resu	ulting in the under	lying	cause given i	n Part I.		23e. Did tobacco
								24a. Was an autopsy performed?
. Was case referred to medical					26	. Place of Dea	th (Ci	heck only one)
examiner? 1 ☐ Yes 2 No	H	ospital: 1 Depatient 2 🗆	ER/Outpatient 3	3 🗆 D	Other:	4 ☐ Nursing He	ome	5 Residence
. Manner of Death		28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d.	Describe how inj

27 investigation 2 Accident

1 ☐ Yes 2 ☐ No

Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check only
	one)

3 ☐ Suicide

4 ☐ Homicide

1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

20052410

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POBOx 1733 SAUSBURY up. 21802 WARU COASTHA - HUIAM 31. Date filed (Month.

State Registrar

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or	State of Maryland / Department of Health and Mental Hygiene

		Please Type or Print in State of Marvi	and / Department of Health and M	ental Hygiene	UU 8 26398
		1 - Stete Registrar	Certificate of Death	Reg. No.	
Physic /Medi		1. Decedent's Name (First, Middle, Last) DOV EDWARD	DENISAR	2. Date of Death Month Day	3. Time of Death 22:7 M
Exami	ner	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		nty of Death e Arundel
Funeral Director		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) Iarch 31, 1927	9. Birthplace (State or Foreign Country) 7 Pennsylvania
death with the Maryland me 23s or 28s-f ehow irmust be notified at	_		. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🔯 No
the Mi	recto	Maryland Calvert 10e. Street and Number	Lusby 10f. Zip Code	10g. Citizen o	of What Country?
th with 23s or	al Di	12981 Barreda Blvd.	20657	Una	ited States
	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Never Married 2 Married 14. Was Decedent Ever in Armed Forces? 15. Was Decedent Ever in Armed Forces? 15. Was Decedent Ever in Armed Forces? 16. Was Decedent Ever in Armed Forces?	If Yes, specify Cuban, Mexican, Puerto I		ace - American Indian, lack, White, etc. cify: White
fled within 72 hours after Hygiene. ther then "naturel", or ite mt, the Medical Evamira	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired)	16b. Kind of	Business/Industry
filled with Hygiene, other the		12	Communications Technical	an Commun	nications
ould be fill Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Harry Denisar	Maria Ec		1119)
2 should be and Mental le marked (aumatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	Route Number, City or Tow	m, State, Zip Code)
1 and 2 Health tem 27 Ither tra		Elizabeth Catherine Denisar / Wife 20a. Method of Disposition 20	12981 Barreda Blvd., Lusby, I		n - City or Town, State
Pages nent of H		1 X Burial 2 Cremation 3 Removal from State	cemetery, crematory or other place) Quantico National Cemetery 08/06,		e, Virginia
permit. Pages 1 an Depertment of Heal Important: If Item 2 any injury or other ance.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ran P.O. Box 600, Lusby, Mar	ısch Funeral Home	
Physician		23a. Part1. Enter the disease or complications that caused that shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not enter the mode of dying, such as cardiac of	respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner	1	resulting in death) Due to (or as a con	Hemorrhagie S	hoch	3 M
te be executed ysicien and e burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Due to (or	GI BLEE	7, COLONIO	3 0
The law requires that the death certificate will have been signed by the attending physoge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Fetal death 3 Ectopic pregnancy		Date of delivery Month Day Year
luires that the signed by lid be deta	by	Part II. Other significant conditions contributing to death but not	CVA	1	ontribute to the cause of death?
The law requires to the has been signed be a	Completed	PURVESSIVE	DEMENTIA	24a. Was an 24t autopsy performed?	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
icien: The certificete h ector, pege	Be	25. Was case reterred to medical examiner?	26. Place of Death	(Check only one)	
Phys rthis ral dir	tion: To	1 Yes 2 No rospital. 1 Inpatient : 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, Day Yea	28b, Time of 28c, Injury at 2	ne 5 Residence 6 C 8d. Describe how injury occ	
al or Attending s after death.	Certification:	2 Could not be		8f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
he Hospit in 24 hour he Funere pletely fille	edicai	(Check only 2 Medical Examiner: On the basis of examiner one) and manner stated.	r knowledge, death occurred at the time, date and place, a mination and/or investigation, in my opinion, death occurred.	ed at the time, date and place	e, and due to the cause(s)
To the transfer of the transfe	X	30. Name and address of person who completed cause of death of the state of the sta	tum 29c. License number D 214?	29d. Date sign	gust 01, 2008
RN 10+	1	30. Name and address of person who completed cause of death of the completed cause of the cause of the cause	(Item 23a) (Type, Print) YUS DEFENSE HGHW	AY ANNAPOL	i) Moziyui
St Regist	ate trar	31. Date filed (Month, Day, Year) AUG - 5 2008	que. B. Sperle		

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		.rtmen <i>tificat</i>			wen		giene / Reg. No.	2008	3 26399	9
	Dii.i		1. Decedent's Name (First, Middle,	_ast)							ate of Dea	ath Day	Year	3. Time of Death	
	Physicia /Medic		RUTH E	RVIN							اساد	30	, 200		
W.	Examin		4a. Facility Name (If not institution, g	rive street and number)			-		Location of Dea			4c. C	ounty of Dea	th	
			MERCY MEDI						MORC		-tt-Dist		0.00	(0)	
ш	Funeral		5. Social Security Number 6	Sex 7. Ag 1 M 21⊈F	e (In yrs. las	Yrs.	If Under Months		If Under 24 Hr Hours Mir	n. (A	ate of Birt	y, Year)	C	thplace (State or Foreign ountry)	1
	Director		213–36–4543 Usual Residence of Decedent		67					4/	6/194	11	Mar	yland	\dashv
	fand ow		10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Inside City Limits	
	Mary -f shi	to	MD Worces	ter	Pocc	moke	City							1 X Yes 2 □ No	
	r 28a	Director	10e. Street and Number	, ccr	1000	MONC	10f. Zip					10g. Citize	n of What C	ountry?	
	h with	0	909 Second Stree	et			218	851					USA		
	ms a	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U .S.	. 13. V	_		spanic Origin? (n, Mexican, Pue	(Specify)	Yes or No	- 14	Race - Ame Black, Whi	erican Indian,	
9	after or ite mine		1 ☐ Never Married 2 Married		No				Specify:	51 to 7 trous	, 0.0.,				
5-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:									specify: wh		
5-	72 h "natu dical	ete	15. Decedent's (Specify only highest)	Education grade completed)		16a. Deced	kind of wo	al Occupa ork done d	ation <i>luring m</i> ost of w)	orking		16b. Kind	of Business	/Industry	
2121	vithin ne. .han ie Me	ם	Elementary/Secondary (0-12)	College (1-4or 5	5+)		emak	,	,			Don	nestic		
2	filed within Hygiene. other than "		17. Father's Name (First, Middle, La			HOI	ellan		18. Mother's Na	ame (Firs	st, Middle,				
anc	antal l	Be C	John Cotter						Jennie						
Z	should be to made to the second marked or umatic every	ျ	19a, Informant's Name/Relationship	(Type, Print)		19b. Mailin	a Address	s (Street a	and Number or I				Town, State,	Zip Code)	_
Maryland	nd 2 s Ith ar 27 is trau		Juergen Ervin (h					,	Pocor						
	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	idsbarid)	20b. Pla	ce of Dispos metery, crem				Date	CILLY			Town, State	
JO.			1 ☐ Bunal 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			sbury C			1	/200	R	Salie	shurv	Maryland	
Baltimore,	_ = # =		21. Signature of Funeral Service Lie		COLLE	22	Name ar	nd Addres	s of Facility					-	
ä	Depar Impor any Ir		Michel	ADem	2	10	3 Lii	ay fi nden	neral H Ave., I	Home, Pocor	, Pro noke	City	nal Asso. , MD 2	1851	
	70		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused	the death.	Do not ente	er the mod	de of dying	g, such as cardi	iac or res	piratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	-		_			OF A				YSM	Onset and Death	
	/Medical		resulting in death)	Due to (or as			, , , ,								
	Examiner		Sequentially list conditions	b. PERIP	HER	M	VAS.	CUL	MR	DUS	SEA	SE			
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as					BACTE						
	and -trans	Examiner	that initiated events resulting in death) Last	c. ACN Due to (or as	GTU (3AU	TOR		BACTE	re	~~	A			_
68760,	fficate be executed g physician and as the burial-transit	E E		Due to (01 us	a conseque	7100 017.									
387	phys phys the	edical	99	d											
		/Me	IF FEMALE:	23c. If yes, outcome	pf pregnan	су						23	d. Date of de	elivery	
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a			Ectopic p Other (s						Month	Day Year	
P.O.	The law requires that the death certi te has been signed by the attending page 2 should be detached for use a	Physician/M	1 Yes 2	9□Unknown											
	res that igned b		Part II. Other significant condition	s contributing to death b	ut not result	ting in the un	nderlying	cause give	en in Part I.		23e. Did t	obacco us	e contribute	to the cause of death?	
or Vital Records,	quire; in sig uld b	Completed by	COPD							_	1 🔲	Yes 2□	No 3□F	Probably 4 Unknown	n
တ္တ	aw requin s been si 2 should i	olete									24a. Was		24b. Were a	autopsy findings available completion of cause of	е
Ä	sician: The law scertificate has be irector, page 2 s	E O									auto perfo 1□ Yes	rmed?	death? 1 ∐ Ye		
ital	hysician: nis certifica director, p	Be C	25. Was case referred to medical						26. Place of D						
<u>-</u>	<u>></u> <u>∞</u> ∨	To E	examiner? 1 ☐ Yes 2 ☐ Ho	Hospital: 1 1 mpatie	ent 2□E	R/Outpatien	t 3 🗆 🗅	OA Othe	er: 4 🗆 Nursing	Home	5 ☐ Resi	dence 6	□Other (Sp	ecify)	
0 _	<u>a</u> ≠ <u>a</u>		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury Work	y at </td <td>28d.</td> <td>Describe</td> <td>how injury</td> <td>occurred</td> <td></td> <td></td>	28d.	Describe	how injury	occurred		
Sio	Attending r death. ector: After by the fune	atic	2 ☐ Accident investiga	he -			М		Yes 2 □ No						
Division	or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin	A ZOE. FIACE UTILIS	ury - At hom c. <i>(Specify)</i>	ne, farm, stre	eet, factor	ry, office		28f. l	ocation (City or To	Street and wn, State)	Number or F	Rural Route Number,	
	urs al		CO. Contifica 1 The artifician	Physician: To the best	of my know	lodge death	000017700	d at the tim	no data and pla	and and	due to the	causo(s)	and manner	as stated	
	Hos 24 ho Fun etely	Medical		caminer: On the basis of and manner st	of examination										
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				29	c. License	e number			29d. Date	signed (Mor	nth, Day, Year)	
	- 7 - 0		Pott Ol	5 /		WO	1	041	76424	J19	11/0	JUL	7 31	,2008	
			30. Name and address of person w	o completed cause of c	leath (Item 2		Print)	- / '	· V130	- / 1	~/ /			,	_
	BA5		BETH JOLL	MERCY M32. Registr	EDICAL	CENT	Ee, 3	3015	ALITE PAUL	PL.	BAL	IMOR	E,M	DZ1202	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	are /	į			,					
	Registi	air	TOUV 31 700 X	ALLO 10 /1720	ng J	Es .	H	T A	40.4Kg 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30,2008 Year **Physician** July 9:00a Ellison Naomi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 411 Hull Place Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 ⋤ F Director 577-26-6007 86 3/12/1922 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville Director MD Montgomery 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 USA 411 Hull Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifWhite 1 □Yes 2√2 No Completed by Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Office Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lela Jane Jones William Franklin Rule 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Hull Place Rockville, Md. 20852 Linda Wolfe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/01/2008 Beltsville, Md 4 Donation /5 ☐ Other (Specify) Chesapeake Crem 21. Signature Funeral Service Licenses PHITTP AD TO ALDI FUNERAL SERVICE, P.A. 9241 Columbia BLvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6days Acute Cerebral Vascular Accident /Medical Due to (or as a consequence of) Examiner <u>Aspiration Pneumonia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed End Stage Dementia

Due to (or as a consequence of): years To the Funeral Director; After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Box 68760 Hypothyroid years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 📉 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 🙀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 31,2008 D54749 eam (Item 23a) (Type, Print) 30. Name and address of person who completed cause of g Allen Reilly 801 Toll House Ave. Frederick, Md 21701 31. Date filed (Month, Day, Registrar's Signature State 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Tranzak 29 2008 Teurae /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2557 Helaine Hamlet Way Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/12/1927 5. Social Security Number 6. Sex. 1 1 M 2 □ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 394-22-8308 Director 80 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2557 Helaine Hamlet Way 21401 United States hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊒Yes 2 □ No If Yes, Give Year or Dates: 1945–51 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) I.B.M. 4 Systems Analyst es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other th ir other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Franszczak Sophie Majchrzak ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Frances A. Franzak/Wife 2557 Helaine Hamlet Way, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/02/2008 | Edgewater, Maryland Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Juneral Service Licenses 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** volor disease or condition resulting in death) 548605 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No the detached 9□Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 Tes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 200 No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

in by the funeral

within 24 hours after death. To the Funeral Director: After To the Hospital or Attending

Medical State Registrar

31. Date filed (Month, Day, Year)

JUL 3 1 2008

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifier

and manner stated.

Rd Sute 300 Annapolis MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rhe 9 40

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

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			Registrar			Cei	rtificate oi	Death	F	Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Last	CREER -	WA	HUT	Œ		2. Date of Dea Month	th Day	708	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death	1	4c. Co	ounty of Death	
			1016 Old Turkey P	oint Rd.			Edge	water			ne Arun	del
	Funeral Director		201-30-7270	M OFFE	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 2/12/1	h y, Yea <i>r)</i> 940	Count	ace (State or Foreign try) ylvania
and	A		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation				10	Od. Inside City Limits
Aarv	t sho	ō	Maran Land Amar Am		,							1 □Yes 2 🛣No
the	7.28a	rec	Maryland Anne Ar	under		Eug	ewater 10f. Zip Code			10g. Citize	n of What Count	try?
with c	33 0	Funeral Directo	1016 Old Turkey P	Point Rd. 21037					-	USA		
death	s E	ner	11. Marital Status	12. Was Decedent E			Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.			14	. Race - America	
A 13-0030	al", or ite Exemina	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	0		fYes, specify Cu 1 □Yes 2k No		o Rican, etc.)		Black, White, e	white
2 P	natur	Completed	15. Decedent's Edu (Specify only highest grad	cation	Ţ.	16a. Dece	dent's Usual Occu	upation of during most of work	king	16b. Kind	of Business/Ind	ustry
od wii			Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. I	irdresse	ed)	Wing	Beau	ıty Salo	n
(1)	- V S	To Be (17. Father's Name (First, Middle, Last) William Harris	on Greer				18. Mother's Nam	ne (First, Middle, ace Patt		ırname)	
ar y shou	snd N s mar	r	19a. Informant's Name/Relationship (7)	rpe. Print)		19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Numbe	r, City or T	own, State, Zip	Code)
, Mai and 2 sh	ealth 27 i		James M. Wallace/	Husband		1016	Old Tur	key Point	Rd., Ed	gewat	er, MD	21037
es 1	of He report of the residual o		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F	Damoual from State	20b. Pla	nce of Dispo metery, cren	sition (Name of natory or other pla	ace)	Date	20c. Loca	tion - City or Tov	vn, State
Pag	ant: I		4 □ Donation 5 □ Other (Specify)	temoval from State	Ka:		ematory	7/29	9/08	Edge	water, 1	MD
permit. Pages	Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Pureyal Service Licens	ee -		- 1	Name and Add	ress of Facility Groomons Isla	eorge P.	Kala Edgew	s Funer	al Home D 21037
\$ 1	ysician Medical caminer		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	157A	TICA		AU (E)			RUNOUA	Approximate Interval Between Onset and Death
certificate be executed	ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a								
the death certifica	n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Pi Fetal o	death 3□	Ectopic pregnar Other (specify)	осу		230	d. Date of delive Month	ry Day Year
w requires that	n signed b ild be deta	by	Part II. Other significant conditions con	ntributing to death but	not result	ing in the ur	nderlying cause g	ven in Part I.		bacco use	1	e cause of death? ably 4 🗌 Unknown
he law req	e has beer age 2 shou	Completed	1						24a. Was a autop	sy med <u>2</u>	prior to con death?	osy findings available npletion of cause of
<u> </u>	ificat or, pa	e C	25. Was case referred to medical						1 □Yes	2 No	1 🗆 Yes	2 No
sicia	s cert	o Be	examiner? -	lospital: 1 ☐ Inpatien	+ 200	D/Outpation	• all poal Ot	26. Place of Dea			7011 12 11	
ding Phy	n. After this funeral o	\vdash	27 Manner of Death 17 Natural 5 Pending	28a. Date of Injury (Month, Day,	/ 2	28b. Time of Injury	28c. Inju	ary at rk?	28d. Describe h		Other (Specify)
or Atten	24 hours after death. Funeral Director. After this certificate has been signed by the atter ettely filled in by the funeral director, page 2 should be detached for u	ertification:	2	28e. Place of Injur- building, etc.	y - At hom (Specify)	ne, farm, stre]Yes 2□No	28f. Location (S City or Tow	treet and f n, State)	Number or Rural	Route Number,
Hospital	24 hours Funeral etely fillec	dical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of a	examinatio	ledge, death on and/or in	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the cred at the time, c	cause(s) a	nd manner as st ace, and due to	ated. the cause(s)

100 State

Registrar

31. Date filed (Month, Day, Year)

JUL 3 0 2008

Registrar's Signature

Director

Be Completed by Funeral

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Medical Certification: To Be Completed by Physician/Medical Examiner

ecedent's Name (First, Middle, Last LYNN MICHE Facility Name (If not Institution, give Shady Grove A								
Facility Name (If not institution, give Shady Grove A						2. Date of Death Ju Month	ly 28, 200	
Shady Grove A		ESPIE	1			OUNI 20	2000	<u>+ 2005</u> м
		Hoeni	1	, Town, or Loca	ville	4	c. County of Dea MONTGO	
ocial Security Number 6. Se	x 7. Age	(In yrs. last birt	hday) If Unde	er 1 Year If U	nder 24 Hrs.	8. Date of Birth	Q Ris	thplace (State or Foreign
218-78-0389] M 2 □ X F	40	Yrs. Months	Days Ho	urs Min.	Sept. 13,	1967	Wash.DC
al Residence of Decedent State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
MD Montgom	ery		erman	town				1 Yes 2 □ No
Street and Number			10f. Z	ip Code		10g. C	citizen of What C	
13200 Chalet	Place, #	301		208	74		U.S.A	•
Marital Status	12. Was Decedent E Armed Forces?		13. Was Dece	edent of Hispan ecify Cuban, Me	ic Origin? (Spe exican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
Never Married 2 Married	1 ∐Yes 2 🔯 N If Yes, Give	0	1 □Yes	2 No Spe	ec <i>ify</i> :	,	Specify: B1	
3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Edu	Year or Dates:	16a.	Decedent's Us	ual Occupation		16b.	Kind of Business	/Industry
(Specify only highest grad	e completed) College (1-4or 5-		(Give kind of w life. DO NOT	ork done during	most of workin	ig i	J.S. Po	_
ementary/Secondary (0-12)	1 yr	' M	lail Ha	andler			ervice	
Father's Name (First, Middle, Last)	- -			18. 1		(First, Middle, Maide		
James Campbel						yn Taylo		
Informant's Name/Relationship (Ty James R. Camp	. ,	ther)	Mailing Addres	S (Street and N Eton	umber or Rura Manor	I Route Number, City Dr , #203	or Town, State, .German	Zip Code) 20876
Method of Disposition	DCII (IC	20b. Place of	Disposition (Na	ame of			Location - City or	
1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Dopation 5 ☐ Other (Specify)	Removal from State	cemeter	y, crematory`or ' Grove	other place)	8/2/		•	burg,MD
Signature of Funeral Service Lipens	ee /	11 1	22. Name a	and Address of F	acility SNO	WDEN FUN	IERAL H	OME, P.A.
Jearge X:x	Sumo	ensh	1					,MD 20850
. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the ler h. Do n	ot enter the mo	ode of dying, suc	ch as cardiac o	r respiratory arrest,		Approximate Interval Between
nediate Cause (Final	Pul	more	110	Eml	21/110			Onset and Death
ulting in death)	Due to (or as a	consequence of	if):	, , , ,				- v w w cy
uentially list conditions,	o							
se. Enter Underlying ase (Disease or injury	Lue to (or as a	consequence o	1).					
initiated events alting in death) Last	Due to (or as a	consequence o	if):					-
	4							
	u					1		
. was decedent pregnant	23c. If yes, outcome of		3 ☐ Ectopic	nregnancy			23d. Date of de	,
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at		5 Other (s				Month	Day Year
1 Other cignificant conditions co		t not requiting in	the underlying	sauss sives in f	Down I	22a Did tobacco	uso contributo t	to the cause of death?
1. Other significant conditions con	. Al At DiA	t not resulting in	A (cause given in F	-ап I.	1 ☐ Yes		Probably 4 \ Unknown
13101101	HOUGH	$\frac{31UII}{}$						
Obesily						24a. Was an autopsy performed?	24b. Were a prior to death?	utopsy findings available completion of cause of
Was case referred to medical					DI	1 □ Yes 2 D		s 2□No
Was case referred to medical examiner? 1 2 Yes 2 □ No	lospital: 1 ☐ Inpatier	nt 2 🗀 🔀 AVOut	tpatient 3 □ C	Other:		(Check only one)	6 □Other (C	anifu)
Vanper of Death	28a. Date of Injur	y 28b. T	ime of	28c. Injury at		ne 5 Residence 8d. Describe how inj	, ,	эсну)
Natural 5 Pending investigation	(Month, Day	rear) Ir	njury M	Work? 1 □ Yes	2 □ No			
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, far . <i>(Specify)</i>	m, street, facto	rv. office	2	8f. Location (Street	and Number or F	Rural Route Number,

State

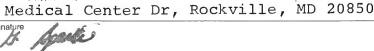
Nicole Vetere 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

01 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Gniadek 30 2008 Julu /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mamico REGIONAL SALISBUM MEDICAL Teninsula CENTER If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Director 85 11-27-1922 344-18-9324 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ty∑Yes 2 □ No Director Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 324 Poplar Hill Avenue 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No 1948— If Yes, Give Year or Dates: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☑ Married 9 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify þ White 3 Widowed 4 Divorced natural", 1950 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: if item 27 is marked other the any Injury or other traumatic event, the 1 once. 12 Grounds Keeper Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Gniadek Mary Kolodziy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona Gniadek - Wife <u>324 Poplar Hill Avenue, Salisbury, MD 21801</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Vet. Cem. E.S. 8-4-08 Hurlock, MD 21643 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Jelissa Heeun 705 E. Main Street, Salisbury, MD 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pramonis **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-trans Physician: The law requires that the death certificate be execute Due to (or as a consequence of): P.O. Box 68760. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Was autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Definying rhysician: To the best of ray intowedge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Definying rhysician: To the best of ray intowedge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 10 160 31. Date filed (Month State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 5115 PM 0 V. Howard 2008 Shirley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Peninsula Regional Medical Salisbury
If Under 1 Year If Under 24 Hrs. WICOMICO Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 11-24-1931 Unknown Director 212-28-4090 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evanairan must be restitled at 1 ☐ Yes 2 No Director Snow Hill MD Worcester 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21863 USA 204 Purnell Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: White Yes, Give Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Services 12 Foster Grandmother 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Be Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9454 Athol Road, Mardela Springs, MD 21837 Dave Brown - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-5-2008 Delmar, Delaware Crematory of Delmarva 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses Bounds Funeral Home Mayon 705 E. Main Street, Salisbury, MD 21804 23a. P.v. 1. Enter the disease, or coor locations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCND **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No filled in by the funeral director, page 2 should be detached signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 □No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifier

State Registrar 31. Date filed (Month, Day,

Year)

0504

Shirley

100

pegistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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· Cornell ST SAlashy wo 2100/

			State of Maryland / Dep		Mental Hygier	ne	
	_		11031011111	ertificate of Death	Reg. I	No. 2008	26406
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) HUBERT L. HURLEY			80°, 2008°	8:15 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
ि हेतू (क्यू			106 Dogwood Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Thurmont V) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederic	place (State or Foreign
	Funeral Director		216-03-7596 X M 2 F 94 Yrs.	Months Days Hours Min.	Jan. 14, 1	ar) Cou	intry) 7 Land
-	put N		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location			10d. Inside City Limits
	Maryla f sho	tor	Maryland Frederick Thurmon				1 XYes 2 □ No
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatilt and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at hijury or other traumatic event, the Medical Examiner must be notified at e.	Funeral Director	10e. Street and Number 106 Dogwood Avenue	10f. Zip Code 21788	10g.	Citizen of What Cou	untry?
	ns 23g	eral		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	
၁	s after (, or iter	y Fur	Arched Forces? 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced Arched Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: WWII	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ĀNo Specify:	o Hican, etc.)	Black, White	ite
2-003p	2 hour	ted b	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b	. Kind of Business/tr	
2 2	within 7; iene. than "n the Medi	Completed by	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work b. DO NOT use retired)	king	C	
7 0	filed w Hygiel other tl	CO	17. Father's Name (First, Middle, Last)	Carpenter 18. Mother's Nam	ne (First, Middle, Maid	Carpentr den Surname)	У
Ian	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	To Be	Elmer Lee Hurley	Maudie (Green		
llar)	12 should h and Men is marke raumatic	ľ		illing Address (Street and Number or Ru			
e,	Healt Healt tem 27		20a Mathod of Disposition 20b Place of Disp	Woodside Avenue, T		LaryLand 2 Location - City or T	
Ē	Pages nent of nt: If ii		1 X Rurial 2 Cramation 3 D Ramoval from State cemetery, cr	rematory or other place) hel Cemetery 8/1/0	08 Fox	ville, Ma	ryland
galt	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Licensee	OBLERT and Address of Facility &		•	
			23a. Part1. En ar the disease, or complications that dause the death. Do not e shock, or heart failure. List only one caus on a th line.	15_EAST_MAIN_STREET enter the mode of dying, such as cardiac		T, MD 217	Approximate
	Physician		shock, or heart fallow. List only the cause of ath line. Immediate Cause (Final disease or condition	10 Oscalus	PU	10	Interval Between Caset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):				J Rece 1
ř	100	er	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury				
	ecuted nd transit	Examiner	that initiated events c.				
5/00,	cate be executed oblysician and the burlal-transit	al Ex	Due to (or as a consequence of):				
200	certificate ding physise as the	edical	d				
Z D D	ath cer ttendin or use	an/N		3□Ectopic pregnancy		23d. Date of deliv	very Day Year
- - -	the deay y the a	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown 9 □ Unknown	5 ☐ Other (specify)			
S,	law requires that the death certific. as been signed by the attending pl 2 should be detached for use as t	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ecords,	w requ	leted			24a. Was an		topsy findings available
1	rsician: The law s certificate has b lirector, page 2 s	Completed			autopsy performed 1□ Yes 2☐	? prior to condeath?	ompletion of cause of
NIT SIL	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	th (Check only one)		
ō	y Phys er this eral dir): To	27. Manger of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how in		ity)
SION	ending ath. or: Afte	atior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
<u> </u>	l or Att after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St		ral Route Number,
	To the Hospital or Attending Physician: The I within 24 Within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, der (Check only one) 2 Medical Examiner: On the basis of examination and/or , and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)
)	ALK		partico quelle 100)	D >) >)	0 0	115	1-60
	7		30. Name and address of person who completed cause of death (Item 23a) (Type Flavio house mo 555 South	Ceuter Street L	NOSTMILLS	to MDG	21157
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1 2008 32. Projectrar's Signature	book			

	1 = For State Registrar	State of Mary		rtificate of		•	Reg. No?	008	2640
	Decedent's Name (First, Middle, Last	t)				2. Date of De		Vaar	3. Time of Death
an al	Paul Joseph	Hefferon				July	28 ^{Day} 20	008 ^{ear}	4:05 P
er	4a. Facility Name (If not institution, give	street and number)			or Location of Dea	ath		unty of Dea	
-	Casey House 5. Social Security Number 6. Se	7 Age //n	yrs. last birthday,	Rockv		s. 8. Date of Bir		tgome	thplace (State or Fore
		M 2 F	56 Yrs.	Months Days			y, Year)	Co	nnsvlvania
	Usual Residence of Decedent					Tourie 1	, 1,5		
'n	10a. State 10b. County Howard	100	c. City, Town or Lo Highla	ind					10d. Inside City Lim
Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	
		I Road		2077	7		Unite		
Funeral	12858 Highland	12. Was Decedent Ever Armed Forces?	in U.S. 13.		·	(Specify Yes or No erto Rican, etc.)	- 14.		erican Indian,
J.F.	1 XX ever Married 2 ☐ Married	1 ☐ Yes 2XXVo If Yes, Give		1 Yes 2000		ano racan, etc.)		Black, Whit ec <i>ifv:</i> Wh	
d by	3 Widowed 4 Divorced	Year or Dates:	160 Dags	7171					
Completed	15. Decedent's Edu (Specify only highest grad	de completed)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	ed) aduring most of w	rorking	16b. Kind o	n business/	/muusiry
mo	Elementary/Secondary (0-12)	College (1-4or 5+)		olesale			Aut	omoti	.ve
BeC	17. Father's Name (First, Middle, Last)					_{ame (First, Middle,} Jean M. C			
卢		ph Hefferon							
	19a. Informant's Name/Relationship (7) Jean M. Heffer		19b. Maili	ing Address <i>(Stree</i>) Hiohlar	et and Number or I nd Road.	Rural Route Numb Highland	er, City or To • MD 2	wn, State, 20777	Zip Code)
	20a. Method of Disposition								Town, State
	1)CHBurial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify	Hemovai from State		osition (Name of ematory or other pla ction Ce			Clinto	•	·
	21. Signature of Funeral Service Licens								nc 6633 01
	Monin Frank	M0025	I			Road, Cli		-	20735
	23a. Pirt1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.				iac or respiratory a	rrest,		Approximate Interval Between
			1 NT1-						
	Immediate Cause (Final disease or condition	Head a	nd Neck	Carcinoma	3				Onset and Death
		a. Head as		Carcinoma	a 				Onset and Death
-G	disease or condition resulting in death)	Due to (or as a co	nsequence of):	Carcinoma	a 				Onset and Death
miner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	nsequence of):	Carcinoma	a				Onset and Death
Examiner	disease or condition resulting in death)	Due to (or as a co	nsequence of):	Carcinoma	a				Onset and Death
ш	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):	Carcinoma	3				Onset and Death
ш	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co Due to (or as a co Due to (or as a co C. Due to (or as a co d.	nsequence of): nsequence of): nsequence of):	Carcinoma	a				
ш	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a co	nsequence of): nsequence of): nsequence of): regnancy Fetal death 3	□Ectopic pregnan			23d.	Date of de Month	
ш	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a co Due to (or as a co Due to (or as a co d. 23c. If yes, outcome pf pi	nsequence of): nsequence of): nsequence of): regnancy Fetal death 3			.,	23d.		livery
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State Registrar MD 6001 Muncaster Mill Rd Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Pririt)

Genevieve Wroblewski

31. Date filed (Month, Day, Year)

JUL 3 1 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:20 p_M Ruth N. Heyser July 1 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House - Montgomery Hospice Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Months Days Hours Yrs. 90 Director 577-28-9623 November 20,1917 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County ıral", or Items 23a or 28a-f shov Examiner must be notlfied at 1 ☐Yes 2 X No Director Maryland Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20906 2921 North Leisure World Blvd., #312 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify Specify: Completed by 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred M. Nash Alma Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Heyser - Daughter 2921 North Leisure World Blvd., #312, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/31/2008 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 Probably 4XJUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? /es 2 \textsq No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2X No 2 3□ DOA 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Specify) Hospice IPU 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: (Month, Day Year) 1 🗷 Natural Injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064615 0 July 26, 2008 were Wha 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 01 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year Henry M. Hofman 30, 6:45 A M July 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **№** M 2 F Days Hours Director 024-12-2910 87 15, 1920 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho 1 ∏Yes 2 ☐ No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6111 Monrose Road, # 310 20852 Funeral U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ۵ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other tt any Injury or other traumatic event, Insonge. Textile Executive Textile is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Abraham Hofmann Rosa Wechsler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Montrose Road, # 310, Rockville, Md. 20852 <u>Pearl M. Hofman - Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemptery, cremators or other place)
Garden of Remembrance
Memorial Park 8/1/2008 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee Edward Sage1 For Uneral Direction, Inc. Sonald. C. Memera 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the dayn. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LCUTE /Medical Due to (or as a consequence of): Examiner 0 20 NA24 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Exami Due to (or as a consequence of): Physician/Medical nding p nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death P 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year signed by the a 2 □ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> ≥ No Be Completed 1 🗌 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform performed? 1 ☐ Yes ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00/808

Registrar
DHMH 17 Rev 1/2001

State

MONTROSE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MID

32 negistrar's Signature

n.

0 1

31. Date filed (Month, Day, Year)

AUG

00-00009	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Larry Gordon Hogan, II	State of Maryland / Department of Health and Mental Hygiene
1- For State	

2008 26410

		Registrar		Certifica	te o	if Death			Reg	g. No.		
Physici		1. Decedent's Name (First, Midd	le,Last)				3.1		ite of Death	Day Year	3.	Time of Death
Medical Exami	ner	Larry Gordon							gust 1, 2	2008		1327 hrs
		4a. Facility Name (if not institution Calvert Memorial Hos		er)		4b. City, Town, or L Prince Frede		Death		4c. County of Calvert	Death	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birth	day)	If Under 1 Year	If Under 2	24 Hr s. 8. D	Date of Birth	(MM/DD/YYYY)	9. Birthp!	lace (State or
Director		214-96-9606	1X M 2 F	43	Yr	Months Days	Hours	N.Aim			Foreign	vMichigan
		Usual Residence of Decedent	121 W 2 F			5.		A	1g. 2	1, 1304	Count	TYMICITIGATI
ану		10a. State 10b. County		10c. City, Town o	r Loca	ation		-			10	od. Inside City Limits
*	_	MD Calver	rt County	Port I	2 2 2	ublic					- 1	Yes 2 X No
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e Ma or 28	Director								100		Country	' :
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r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 X M		es?		as Decedent of Hisp Yes, specify Cuban,				14. Race - White,		n Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once			1 Yes	2 X No	1	Yes 2 X No	ana aife			C*	TIT	
ırs af ı ura l'	ģ	15. Decedent's Education (Spe	or Dates:	completed) 16a D		nt's Usual Occupation		d of work do	one I	Specify: 16b. Kind of Busi	White	
2 hou	죑	Elementary/Secondary (0-12)		- di	iring r	nost of working life. I	DO NOT use	e retired)		TOD. TAILS OF BUSI	1033/11100	25() y
thin 36	Completed	12	+2	Son	Or	Distribu	tion S	9pera System		Utilit	77 Co	mnonti
15-003 filed withi Hygiene. d other th	9	17. Father's Name (First, Middle		Dell	.01					aiden Surname)	y co	mparry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medical	Be	Larry Gordon I	logan				Schera	al Ela	aine N	Welch		
2121 hould be find Mental is marked	٩	19a. Informant's Name/Relations		19b.	Mailir	ng Address (Street					State, Zi	p Code)
e, MD 21215-0036 1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than "		Rhonda S. Hoga	an (Wife)	48	348	Independe	ence I	Drive	. Por	t Republ	ic.	MD 20676
		20a. Method of Disposition	. —	20b. Place of	Dispo	sition (Name of cementher place)	etery.	Date		20c. Location - C		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other S		I _	_	ematory		August	008	Clinton	Mo	muland
altin nit. P. sartmes sortan try or	- 1	21. Signature of	ecity:	1 пее	22.	Name and Address	of Facility T		mera	Home C		rt DA
Balt permit Depart Impor injury	- 1	Michaela. I	iee.			25 Souther						
Physician	\dashv	23a. Part I. Enter the disease, or	complications that caus	ed the death. Do not	enter	the mode of dying, s	uch as card	diac or respi	ratory arres	st, shock, or hear	50,	Approximate Interval
/Medical		failure. List only one cause	NAMES OF THE PARTY OF	96							- 1	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor								_	
	.	Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):								
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e execian a	an/Medical	UNPENDED	AMENDED									
68760, ertificate bu ding physic e as the bur	Š	IF FEMALE:	23c. If yes, outo	come of pregnancy	_	-				23d. Date of de	elivery	
687 ertifi ding	ian/	23b. Was decedent pregnant in the past 12 months?	Live birth	2	Fe	etal death 3	Ectopic pr	regnancy		Month	Day	Year
Box e death c the atten ed for us	sic	1 Yes 2 No 9 Uni	known g Unknown	at time of death 5	0	ther (Specify)						- 1
P.O. Box 6: s that the death cert med by the attendin	Physicia	Part II. Other significant condit		ath but not reculting	n tho	underlying course six	on in Dort I	. 12	20 Did tob	acco use contribu	ito to the	acuse of death?
, P.O. res that th signed by be detach	ğ		iono contributing to de	atti bat not resulting	ii tiile	underlying cause giv	en in Fait i.					ly 4 Unknown
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Rec The I	ğΙ							1	✓ Yes 2		ath? ✓ Yes	2 No
ital Recions The secrificate rector, page	Be	25. Was case referred to medica examiner?				26.Place o	of Death (Ch	neck only or	ne)			
Vit hysic this	ા	1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 🗸 ER/Out	oatien	t 3 DOA	ther N	lursing Hom	ne 5 R	tesidence 6	Other:	
Division of Vital Records, is lor Attending Physician: The law requir is after death. al Director: After this certificate has been sed in by the funeral director, page 2 should the fine for the control of the funeral director.	- 1	27. Manner of Death	28a. Date of In (Month, Date) Aug 1, 2008	njury 28b. Ti		Injury 28c. Injury	at Work?	28d. [Describe ho	ow injury occurred	od wit	h outo
ttend death.	ati	Natural 5 Pend 2 ✓ Accident Inves	stigation Aug 1, 2008	1214	nrs	1 Ye	s 2 V No	° IMOLO	reyole (unver comu	su witi	n auto
or A after Direc	≝	3 Suicide 6 Coul	d not be 28e. Place of	Injury - At home, farr	n, stre	et, factory, office bui	lding, etc.	28f. L	ocation (St	reet and Number	or Rural	Route Number, City
D ours ours filled	Certification:	4 Homicide	mined (Specify)	ocal Street				Broon	nes Island	Road and Hov	vard Ro	ad, Port Republic,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier (Check only 1 Certifying PI	nysician: To the best of	my knowledge, death	occu	rred at the time, date	and place,	, and due to	the cause	(s) and manner as	s stated.	
To th withit To th	Medical		miner:On the basis of ex and manner state	kamination and/or inv d.	estiga			red at the ti	me, date ar	nd place, and due	to the ca	ause(s)
	Σ	29b. Signature and title of certifie				29c. License	number			29d. Date signed	(Month,	Day, Year)
		Marhona	The Chos	2		O.C.M	.E.			August 2, 20	80	
rad .	t	30. Name and address of person	who completed cause o	f death (Item 23a)								· · · · · · · · · · · · · · · · · · ·
KW ID	[Margarita Korell MD.	Assistant Medica	al Examiner 1	11 P	enn Street, Bal	timore, N	MD 2120	1			
	ate	31. Date filed (Month, Day Year)	4 2008 ^{32. Relist}	rar's Signature		- P -						
Regist	rar	AUG	- 2000	ever B.	AD	exter						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26411

		1- For State Registrar		Certifi	cate of De	eath	eritai Hygiene	Reg. No.	08 264
Physic al Exan			n Hughes				2. Date of D Month August	eath	3. Time of Death 1728 hrs
· E		4a. Facility Name (if not institutio 12595 Santa Rosa Cir	n, give street and number)	·		ity, Town, or Locati	ion of Death	4c. County of De	
Funera		5. Social Security Number		(In yrs. last b		ISby Under 1 Year If L	Inder 24Hrs. 8. Date of	Calvert Birth(MM/DD/YYYY) 9.	Diale (Co.
Directo		216-08-4523	1 M 2 X F	41	-		ours Min. 08–0	1 1067 For	eign Country
any		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Tow	n or Location				MD
felf laryland Sa-f show at once,	5	MD Calv		Lusby					10d. Inside City Limits 1 Yes 2 X No
he Mary or 28a	Director	10e. Street and Number 12595 Santa Ros	a Circle	7. 1	10f	Zip Code 20657		10g. Citizen of What Co	
h with 1		11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec	cedent of Hispanic	Origin? (Specify Yes or I	United St	ates erican Indian, Black,
ter deat	Funeral	1 Never Married 2 X Ma 3 Widowed 4 Dive	1 Yes 2	X No	if Yes, sp	ecity Cuban, Mexic	can, Puerto Rican, etc.)	White, etc.	
iours afi iatural' xamine	d by	15. Decedent's Education (Spec	orced or Dates: ify only highest grade comp	eleted) 16a	. Decedent's Us	2 X No spec	ve kind of work done	Specify: V	White
0036 within 72 h jene. ner than "n	pleted	Elementary/Secondary (0-12)	College (1-4 or 5+	+)	dunng most of	working life. DO N	OT use retired)	TOD. INITIO OF BUSINESS	sindustry
5-00 lled with Hygien I other	Comple	17. Father's Name (First, Middle,			Housewi		her's Name (First, Middle	Own Home	
21215-0036 uld be filed within 7. Mental Hygiene. marked other than	To Be	Guy Norman Smit 19a. Informant's Name/Relationsh				Mai	rgaret Schul	lz	
Baltimore, MD 21215-0036 Department of Eleath and 2 should be filed within 72 hours after death with the Maryland Department of Eleath and Mental Hygiens I maperiant. If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be nofficed at once,	-	Daire VanCott F		and)	96. Mailing Addr L2595 Sa	ess (Street and Nanta Rosa	lumber or Rural Route No Circle, Lu	umber, City or Town, Sta	te, Zip Code)
Ore, geslan t of Hea . If iter		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from State	20b. Place	of Disposition (itory or other pla	Name of cemetery,	Date	20c. Location - City of	
altim nit. Pag artment sortant: ry or o		4 Donation 5 Other Spe 21. Signature of Funeral Service L	ecify:		opolita	n Cremato	ory 8-12-08	Alexandr:	ia, Virginia
_ ===:-	g 19	5t. 9. 5th			P. (and Address of Fac	naaban 1	Funeral Home	P. A.
Physician Medical		23a. Part I. Enter the disease, or c failure. List only one cause o			ot enter the mo	de of dying, such as	s cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
∠xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	intox:	ication	(hydroco	odone, trama	idol)	Death
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or es a noneage	Jerice of :					
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ						
3760, ficate be executed g physician and the burial - transit			d						
8760, ifficate be e. ig physician is the burial	//Medical	X UNPENDED				4E, g882	8/20/08 TT		
		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2		th 3 Ecto	pic pregnancy	23d. Date of deliver Month	Day Year
Box ie death the atte	Physiciar	1 Yes 2 No 9 V Unkno	9 Unknown	ne of death	Other (S	pecify)			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ē	Part II. Other significant condition	ns contributing to death bu	ut not resulting	g in the underly	ng cause given in I	Part I. 23e. Did t	obacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed						1 Ye		bably 4 V Unknown
tal Reco	omo						autor	prior to death?	utopsy findings available completion of cause of
ician: s certifi	Bec	25. Was case referred to medical examiner?	Hospital:			26.Place of Deat	1 Yes	2 No 1 Y	es 2 No
n of Vi ling Physi After this funeral dire	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. 1	Itpatient 3	DOA Other 2 28c. Injury at Wor	Nursing Home 5	Residence 6 Othe	r: Scene
Ivision or Attendi after death. Director: /	atio	1 Natural 5 Pending 2 Accident Investig	ation Fnd 8/6/0	8 Fnd	5:00pm	1 Yes 2	K No unk	now injury occurred	
Divis	ertification:	3 Suicide 6 X Could n	ot be 28e. Place of Injury	- At home, fa	rm, street, facto	ry, office building, e	or Town, S	Street and Number or Rustate) 121595 Sa	iral Route Number, City
c Hospital 124 hours c Funeral	\circ	29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, dea	th occurred at ti	ne time, date and n	CITCLE	Lusby, MD	
To the Hos within 24 h To the Fm completely	- G	 Medical Examination Signature and title of certifier 	ner:On the basis of examina and manner stated.	ation and/or in	ivestigation, in r	ny opinion, death o	ccurred at the time, date	and place, and due to th	e cause(s)
		IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	101	a)	21	O.C.M.E.		29d. Date signed (Moi	nth, Day, Year)
	3	0. Name and address of person wh						August 7, 2008	
Sta	ite 3	Melissa Brassell, MD 1. Date filed (Month, Day, Yeer)	Assistant Medical Ex		- 2	treet, Baltimor	e, MD 21201		
Registr	ar	1. Date filed (Month Day, Year) 2	2008 32. Figistrar's S	J.	Spark	•			

ORIGINAL

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: after death Director: 24 hours a within 2 To the

2

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Sate filed (Month

30. Name and address of person who

29b. Signature and title of certifier

29a. Certifier

(Check only one

and manner stated.

€ompleted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3 Pay Darlene Louise Jacobs 2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Campia HOSAHal | If Under 1 Year | If Under 24 Urs | 8. Date of Birth (Month, Day, Aug. 9) 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. ast birthday) **Funeral** 1 □ M 2 🗓 F 218-50-2280 60 1947 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3735 Sunnyside Road 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🗓 No Specify þ White 3 Widowed 4 Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Maren Ingent Item Item Inc. Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman C. Prchal ၉ Genevive Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James F. Jacobs/Husband P. O. Box 142, Secretary, Maryland 21664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2008 Delmar, Delaware 21. Signature of Funeral Service bicer 1 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Part. Enter the disease, or com lications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** how disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Una Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last cance Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2<mark>™</mark>No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Certification: To this 24 hours after death.

e Funeral Director: After thioletely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, Hospital or Attending Physician: 24 hours after death.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 7 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408 M.D 31. Date filed (Month, trar's Signature State Registrar

29d. Date signed (Month. Day, Year)

3008

			1 - State Registrar Amend Items 2332121 Mary 1332 FD FD	artment set le			giene Reg. No.	008	26414
П	Physici	an	Decedent's Name (First, Middle, Last) TARREST NAME (First, Middle, Last)			2. Date of De Month		Year	3. Time of Death
	/Medic	cal	KATHLEEN ANNE JOHNSON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	July	100	2008	0706 M
	Exami	lei	ENINSULA REGIONAL MED. CENTER	SALI	shuny			comi	co
П	Funeral		5. Social Security Number 0 6. Sex 7. Age (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birthpla	ace (State or Foreign
	Director		Usual Residence of Decedent			JUNE 2,	1932	WASHI	NGTON, D.C.
	ırylanı show	_	10a. State 10b. County 10c. City, Town or Lo	ocation				10	d. Inside City Limits
	he Ma 28a-f	Director		SBURY					1 XYes 2 No
	with t		300 UNION AVENUE	10f. Zip Code 2180	01		10g. Citizen o	f What Count	
	death	Funeral		Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No	- 14. R	ace - America	an Indian,
21215-0036	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Eranina court to notified at	þ	1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No	_	Specify:	rican, etc.)		lack, White, et	
2-0	72 ho 'natur	Completed		edent's Usual Occupation		na I	16b. Kind of	Business/Indu	ustry
121	within ene. than '	James 1	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) HOMEMAKER	The state of the s	9	O.	ти пом	,
2	il Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)		8. Mother's Name	(First, Middle,		VN HOME	
/lar	should be and Menta s marked umatic ev	TO B	JACK MCRAE COLLINS		HELE	N NICHO	LSON		
Maryland	au isi			ng Address (Street and					*
	1 and Health em 27 ether ti			UNION AVEN		SBURY,		ND 2180	
ē	ë = 5		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State	osition (Name of matory or other place) XE CREMATI (JST 1		-	
baltimore,	permit, Pag D. partmen In portant; any injury one.			2. Name and Address ELLOWS, HEI					MARYLAND
n	45 E 2		100 11. TUTE 10	D6 SHAMROCK	K ROAD,	CHESTER	, MARYI	AND 21	HUME, P.A. 619
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause in each line. Immediate Cause (Final	ter the mode of dying,	such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
No on	Physician /Medical		disease or condition resulting in death)	heart of	for home	-			Offiser and Death
	Examiner		Due to (or as / consequence of):	n		O Jun)	4	Lan
	eit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that believes as or injury that believes to the condition of the con		لاكما	VED BY MEDICA	LEXAMI		
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events c	10	OLATICATION APPRO	MEDBO			
20	ficate be executed physician and s the burial-transit	dical E	Due to (of as a consequence of).	CEP	STIFICATION				
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Š Q	ath ce ttendir or use	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moptris? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	☐ Ectopic pregnancy			I .	ate of deliver	•
- 5	Ine iaw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			"	Month [Day Year
ν, Τ	s that gned b e deta	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given	in Part I.	23e. Did to	obacco use co	ntribute to the	cause of death?
Records	equire		Kight ferneral nest from	Ane		1 🗆 \	res 2⊒Ho	3 ☐ Proba	ıbiy 4 ☐ Unknown
ဋ	has b e 2 sh	Completed	Prior CVA'S			24a. Was	sv	. Were autop:	sy findings available pletion of cause of
VII P	n: In fficate or, pag		Morbid obesity			1 □ Yes	rmed?	death? 1 ☐ Yes 2	2 □No
= :	ysicia is cert directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ mpatient 2 ☐ ER/Outpatien	Othor	26. Place of Death	·		ub (0 - 16)	
	ng rn fter th	T:uC	27. Manner of Death 28a Date of Injury 28h Time o		4 ☐ Nursing Hor	28d. Describe h	now injury occu		<u> </u>
2 .	tendil leath. tor: A the fu	catio	2 Accident investigation July 10, 2008 Unknow	wan ^M 1□Yes	s 2 XNo	Subjec	t fell		
	ral or Arris after or al Director al Director led in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) Home	eet, factory, office	2	City or To u	Street and Num vn, State) 30 ury, M	Ollmia	Route Number, n Avenue
	To the hospital of Attending Physician: The law requires that the death certification within 24 hours after death. To the Tuneral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my <u>o</u> pin	vion⊾ death occurr	ed at the time,	cause(s) and i	e, and due to t	ated. the cause(s)
ř	withii To the comp	M	29b. Signature and title of certific	29c. License n	number		29d. Date sign		ay, Year)
	194		turando J. Cule, mis	0009	11211		July	28,2	1008
	AA		30. Name and address of person who completed cause of death (Item 23a) (Type, FERWAN do J. Mc/E MD 100 E. CARROLL ST	Print)	44	, , , ,	1		
	Sta	te	31. Date filed (Month Day Year) 0 2008 32. Figistrar's Signature	· ZHIISBU	ing me	. 218	01		
	Registra		31. Date filed (Month, Day, Year) 0 2008 32. Figistrar's Signature	القامين					

			For State Registrar	State of Mary	yland / Depa <i>Ce</i>	artment of F rtificate of I	lealth and N Death		giene 2 (Reg. No.	08	26415
1	Physici /Medio	al	1. Decedent's Name (First, Middle, La	m. K	amme		a la casa de Booth	2. Date of De- Month	27 2	Year 200 %	3. Time of Death
	Examin Funeral Director	er	,	Rd.	In yrs. last birthday) 83 Yrs.		gewater If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 4/14/1		Arun	lace (State or Foreign
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	Dc. City, Town or Lo	ocation dgewater					0d. Inside City Limits 1 □Yes 🏋 No
	th with the 23a or 28	ral Director	10e. Street and Number 3902 Calawassee I	Rd.		10f. Zip Code	037		10g. Citizen of V US		try?
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evan, nor oust be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	ce - America ck, White, e y: Whit	etc.
2	- 1.75	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired omemaker	ation during most of work d)	ing	16b. Kind of Br	usiness/Ind	ustry
Maryland 21	should be filed within nd Mental Hygiene. marked other than umatic event, how	To Be C	17. Father's Name (First, Middle, Last John Feathers)		лшешакет	18. Mother's Nam	e (First, Middle,			UNK
	1 and 2 sho Health and I em 27 is ma other trauma		19a. Informant's Name/Relationship Allen J. Kammer	Son	72 Du	ng Address (Street	e Edgewat	er, MD	21037		
altimore,	Page nent c ant; If ury or		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Hemovar from State	20b. Place of Dispo cemetery, cres Hillcrest	Cemeter	y 8/2/	2008	20c. Location - Annapo1:	is, MI	D
Bai	permit. Departi Importa any Inji		21. Signal de of Funoral Service Nice		1	2. Name and Address 2 Ridgely	y Ave. A	nnapoli	s, MD 2	1401	
	Physician /Medical Examiner		23a. Part1. Enter the disease or complete shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	pplications that caused the one cause on each line. a. Due to (or a vice)	Atock	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest, - OM J7-		Approximate Interval Between Onset and Death
58760,	ificate be executed g physician and is the burial-transit	edical Examiner	Sequentially list conditions, it ary, leading to minidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
Box	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	☐ Ectopic pregnanc	у			ite of deliver	ory Day Year
ords, P.	law requires that the de as been signed by the 2 should be detached	ρ	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	<u>.</u>		e cause of death? ably 4 Unknown
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or VII	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		2 ER/Outpatier		4 ☐ Nursing Ho	ome 5 Resid	dence 6 □Oth		·)
DIVISION	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ertification:	2 Accident 3 Suicide 6 Could not be determined	e Opo Bloco of Injury	- At home, farm, str	M 1	y at {? Yes 2 □ No		now injury occurr Street and Numb vn, State)		Route Number,
	le Hospital n 24 hours le Funeral pletely filled	edical C	29a. Certifier (Check only one) 1 Certifying Pi 2 Medical Example	hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	within to comp	N M	29b. Signature and title of certifier	R	e mo	29c. Licenso			29d. Date signe		
_	1/BX		30. Name and address of person who	. Jone	28, ms	Print) 613	1 5hA	de S	ide	RI	18 20764
	Sta Registra		31. Date filed (Month, Day, Year) JUL 3 0 20	108 Segistrar's	Jr A	arte		1			

		For State Registrar		State of M	aryland		artment of H <i>rtificate of E</i>		nd M		giene Reg. No)8	2641
			e (First, Middle, Las	t)						2. Date of De	ath			3. Time of Death
Physicia /Medic		F	RANKIE	Eugene	Ι	LYDARD	, SR.			AUGUST	7,	2008 Ye	ar	8:14A M
Examin	er			street and number)			4b. City, Town, or FREDE		Death			. County of D FREDER		
Funeral		5. Social Security N	lumber 6. S	ex 7. Ag		ast birthday)	If Under 1 Year	If Under 24		8. Date of Bir (Month, Da	th	9.	Birthplac Country	ce (State or Foreign
Director		213-38-0	231	Д м 2□ F	71	Yrs.	Months Days	Hours	Min.	Nov. 2	4, 1	936		yland
land ow	i	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation						10d	. Inside City Limits
a-fsh	ctor	Maryland	Fredei	ick			Jeffe:	rson						1 □Yes 2√√ No
or 28	Director	10e. Street and Nu					10f. Zip Code				10g. Ci	tizen of What		?
eath w	Funeral		fferson E	12. Was Decedent	Ever in 116	2 13		755	in? (Sne	nify Ves or No		U.S.A		Indian
r Item		11. Marital Status 1 Never Marr	ied 2□ Married	Armed Forces? 1 ∏ Yes 2 □)	54-	Was Decedent of His If Yes, specify Cubar		Puerto F	Rican, etc.)		Black, W		
ral", o	d by	3 🗆 Widowed	4 X Divorced	If T es, Give Year or Dates:	196		1 ☐ Yes 2 🙀 No	Specify:				Specify:	Whit	te
n 72 h "natu	Completed	(Spec	15. Decedent's Ed	ucation de co <i>mpleted)</i>		16a. Dece (Give	edent's Usual Occupa e kind of work done d DO NOT use retired)	ition <i>uring most</i> o	of workin	g	16b. k	Kind of Busine	ss/Indus	stry
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e filec al Hyg d othe	Be C	17. Father's Name	(First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)						
ould b	To		mas Lydaı			1	Annie Nicholes ailing Address (Street and Number or Rural Route Number, City or Town, State							
d 2 sh th and 7 is m traum			ame/Relationship (* E. Lydaro		Son)		ing Address (Street a Maplevil						-	
s 1 an of Heal item 2		20a. Method of Dis		.,			osition (Name of matory or other place		Da	ate		ocation - City		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Department of Health and Mental Hylgiene. Department if item 27 is marked other than "natural", or items 23a or 28a-f show mortant: if item 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evan and the notified at once.			☑Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State ()			rg Cremato	1 4	Augus 200	st 9,	S	mithsb	urg,	. Maryland
ermit. epartr nporta ny Inje		21. Signature of Fu	uneral Service Licen				2. Name and Addres	_	U			Funera		
<u> </u>	_	Post Salar	the disease or some	TIVID	MO 141		2525 Bradi					g, Mar		nd 21783
Dhusisian		shock, or hea	art failure. List only	one cause on each l	ine.					-	inost,		Ir	nterval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	o'n	a. PO>			tet en	ווטכוו	2 11)			-	
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ted sit		Sequentially list co if any, leading to in cause. Enter Under Cause Observed	nmediate erlying	Due to (or as	a consequ	uence of):		4	I					
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ficate be executed physician and s the burial-transit	edical	L d.												
Physician: The law requires that the death certificate be execut this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-tran		IF FEMALE:			_	_								· · · · · · · · · · · · · · · · · · ·
eath certifi attending for use as	Physician/M	23b. Was deceden in the past 12	months?	23c. If yes, outcome 1 Live birth 4 Pregnant	2 Fetal	I death 3	☐ Ectopic pregnancy					23d. Date of Month		ay Year
the d	hysic	1 ☐ Yes 2 9 ☐ Unknowr		9 Unknown	at time of o	icaii 5								
es that gned I	by P	Part II. Other signi		_		_	underlying cause give							cause of death?
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ysicle is cert direct	To Be	examiner?		Hospital:	ient 2 🔲	ER/Outpatie	ent 3 DOA Othe	r.		(Check only ne 5 ☐ Res		6 □Other (Specify)	
ding Physician: The law requires that the de n. After this certificate has been signed by the funeral director, page 2 should be detached	on: T	27. Manner of Dea	th 5 Pending	28a. Date of Inj (Month, Da		28b. Time Injury	Work	/ at		8d. Describe				
ttendi death. stor: / the fu	icati	2 Accident	investigation 6 ☐ Could not be		iun, Atho	me farm e	M 1 □ 1	/es 2□N		Rf Location	(Stroot o	and Alumbar o	r Pumi I	Route Number,
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ospita hours unera uneral		29a. Certifier (Check only					ath occurred at the tin							
To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)		and manner s			29c. License			T		ate signed (M		
₽ ₹ ₽ 8	-	29b. Signature and	m clay	. M.D	•		D.C.	~ ~	40	110		10-20		_
		30. Name and add	ress of person who	completed cause of		n 23a) (Type	, Print)	,			5	1000		
W.W.		PRATIM	A PAND	EY 40	0 W.	7-16		ederic	cle	MD	21	701		
Sta Registr		31. Date filed (Mon		32 degist	rar's Signa	ture	200							
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State of Maryland / Department of Health and Mental Hygiene-For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician HN 08 2317 M 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JULY 19,1943 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 12M 2 F NEW YORK 042 34 1620 65 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 243 LONG POINT ROAD UNITED STATES 21032 or Items 23a filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 GYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 BUDGET ANALYST FEDERAL GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if item 27 is marked oth eny linky or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN LIPP II IRENE HOYT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED Y. KEULL (WIFE) 243 LONG POINT ROAD CROWNSVILLE, MD. 21032 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State KALAS CREMATORY 07-31-2008 EDGEWATER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME Ulac 2973 SOLOMONS ISLAND ROAD EDGEWATER.MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director; After this certificate has been signed by the attending physicien and burial-transit Due to (or as a consequence of): Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred J □ Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a Hospite Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 4 completed cause of death (Item 23a) (Type, Print) . Name and address of person wi DEFENSE IT GHWAY TWNAPUNS MAZIYOI 11CH MEZ 31. Date filed (Month, Day, Year) egistrar's Signature 3 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:57 P™ Aug. John A. Lepage 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Days Hours Min. 1 X M 2 □ F 83 PA Director 196-12-5562 June 8, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Funeral Director 28a-f Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Widcal Evandratic rust bor 77 Hingham Lane 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married DのB で6/08/19ユラ Do D - 08/02/3038 で175 Baltimore, Maryland 21215-0036 1 □Yes 2 1 No Specify: white Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>supervisor</u> manufacturing com. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Germaine Lepage Elizabeth Hornicak ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Hingham lane Ocean Pines, MD 21811 Vera Lepage - wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Cape henelope crematory Aug. 4, 2008 Frankford, Delaware 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lic 22. Name and Address of Facility 108 Williams street Berlin, MD 21811 23a. Part tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a a consequence of): /Medical Examiner Due to (or as a consequence of): Se uentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Pivision of Vital 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/08 Do0 64120 30. Name appradoress of person who completed cause of death (Item 23a) (Type, Print) 9733 Health way Drive Berlin M. D 21811 BA 10+1 Zeeshan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2008 Registrar

Le pa 27

John

08-06050 Fredrick LeNeave Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26419

Cui	IOR LEIVEAV	1	- For State	Certi	ficate of E			Reg. N	0.	00 2041
	Physicia	an/	Decedent's Name (First, Middle,Las	1)			2	Date of Death Month Day	y Year	3. Time of Death 2152 hrs
F	ા Exami		Frederick Rudolp					Month Day August 7, 200	98 4c. County of Death	
			 Facility Name (if not institution, given 214 Pennsylvania Ave. Ap 			City, Town, or Locat Hancock	ion of Death		Washington	
			5. Social Security Number 6. Se				Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or
	Funeral Director	- 1			86 Yrs.		Auro Min	December 13	Foreig	
	Birector	L		M 2 F	OO Yrs.			adile 1	0,1021	INC
	алу	- }	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
	*		MD Washingt	on Hanc	ock					1X Yes 2 No
	Aaryland 28a-f show 1 at once,	Director	10e. Street and Number			Of. Zip Code		10g. (Citizen of What Cou	ntry?
	ath with the Maryland items 23a or 28a-f sho ist be notified at once.	ä	214A Pennsylvani	a Avenue		21750		US	SA	
	with ns 23:	<u>a</u>	11. Mantal Status	12. Was Decedent Ever in U.S.		Decedent of Hispanic , specify Cuban, Mex			14. Race - Amer White, etc.	ican Indian, Black,
	death or iter nust	Funeral	1 Never Married 2 Married	1 X Yes 2 No				ican, ctc.,		
	after	b.		If Yes, Give Yeer or Dates:		es 2 X No spe Usual Occupation (0		di dana 1161	Specify: White	
	hours "natur		15. Decedent's Education (Specify o Elementary/Secondary (0-12)	College (1-4 or 5+)		t of working life. DO			b. King of Business	industry
	36 iin 72 han '	ple	4	College (14 of 51)	Carpen	ter		F€	ederal Gov	vernment
	21215-0036 sold be filed within 72 Mental Hygiene. marked other than '	Completed	17. Father's Name (First, Middle, Last)			other's Name (First, Middle, Maid	len Surname)	
	21215-0 ould be filed w Mental Hygid marked othe	Be (Thomas Henry LeN	eave			agia Le			
	D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiene, it is a first that hygiene is a first in market other than "natural", or items 23a or 28a-fish afte event, the Medical Examiner must be notified at once	ည	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	Address (Street and	Number or Ru	ral Route Number	, City or Town, State	e, Zip Code)
	MD ad 2 sho alth and alth and m 27 is		Ronald G.LeNeave	/Son	9596 J	ames Rive	er RD St	nipman, \	7A 22971 Dc. Location - City o	Town State
			20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State Cr	ematory or othe	r place)	·		•	
	Page Page ment o		4 Donation 5 Other Specify	st.		Cemetery	_		Clear Spr	
	Baltimore, bermit. Pages 1 ar Department of Her Important: If ite injury or other tr	. 4	21. Sign ture of Fulleral Service Lice	nses	22. Na	me and Address of F	facility 141	West Ma	ain Street	1750 0260
			23a. Part I. Enter the disease, or com-	lications that caused the death. I	Grov Do not enter the	re Funeral	Home,	P.A.Hano	shock, or heart	Approximate Interval
	hysician Wedical		failure. List only one cause on e	ach line.		g, 555.				Between Onset and Death
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	cuted ind transi	<u> </u>	d							
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be deached for use as the burial - transit	Medical	UNPENDED	AMENDED						
	Box 68760 death certificate be the attending physical of for use as the bu	/We	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna		3 5	Ectopic pregnar	2014	23d. Date of deliver Month	ry Day Y ear
	Sox 687 death certific e attending for use as t	cial	past 12 months?	1 Live birth 4 Pregnant at time of dea	*b	Il death 3 E er (Specify)	ctopic pregnar	lcy	Wichtin	buy rous
	Box e death the atte	Physician	1 Yes 2 No 9 Unknow	g Unknown						
	O. l at the dby t		Part II. Other significant conditions	contributing to death but not re-	sulting in the un	derlying cause given	in Part I.			o the cause of death?
	ords, P.O. In requires that the as been signed by a should be detached.	Completed by				16.	Arr .			obably 4 Unknown
	v request speed	je						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
	ecc he lav ate has	Į į	ri .					performe 1 V Yes 2		
	tal Recions: The certificate rector, page	BeC	25. Was case referred to medical				Death (Check o	nly one)		
	Vit.	۱ ٥	examiner? 1 ✓ Yes 2 No		ER/Outpatient				esidence 6 🗸 Oth	er: Scene
	fung Ph. After ti		27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of In			28d. Describe hov Subject shot s	w injury occurred self	
	ivision or Attend after death. Director:	jä ä	1 Natural 5 Pending 2 Accident Investiga	tion Aug 7, 2008	2110 hrs	ha.	2 V No	000 1	and and Northern as I	Rural Route Number, City
	Division of Vital Records, ospital or Attending Physician: The law require hours after death. Inneral Director: After this certificate has been signeral Directors. After the receiving a Villed in by the funeral director, page 2 should by Villed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could no determin		d who	, factory, office build		or Town, Stat		/
	Hospital 24 hours Funeral		4 Homicide	cian: To the best of my knowledg		ad at the time date a				
	To the Hos within 24 h To the Fur	ical	29a. Certifier 1 Certifying Physicone) 2 Medical Examine	er:On the basis of examination ar	nd/or investigation	on, in my opinion, de	ath occurred a	t the time, date an	d place, and due to	the cause(s)
	To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.	- 10	29c. License nu			29d. Date signed (A	
	7		his his	, ND		O.C.M.E	≣.		August 8, 2008	
			30. Name and address of person who		23a)		-			
			Ling Li, MD Assistant I			t, Baltimore, MD	21201			
			31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re Laga	K.				
	Reni	strar	AUG 1 5 2	008 Brown D	A STATE OF THE PARTY OF	-				

08-06043 Emma Leiby Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26420

		1- For State Registrar	-	Certifi	cate of	Death			Reg	ı. No.	
Physicia	an/	Decedent's Name (First, Midd							Date of Death Month	Day Year	3. Time of Death
al Exami			Emma Je						August 7, 2	8008	1816 hrs
		4a. Facility Name (if not instituti 54 Greenwood Street	_	Γ)	41	o. City, Towi Elkton	n, or Locat	tion of Death		4c. County of Dea	atn
		Social Security Number		ge (In yrs. last b	viethday/)	If Under 1	Vear I II	Under 24Hrs	8 Date of Birth		Birthplace (State or
Funeral Director							_	lours Min			eign West Country) Virginia
Bileotoi		217-60-2444	1 M 2 X F	56	Yrs.	<u> </u>			NOV 7,	1951	Journal of the second of the s
any		Usual Residence of Decedent 10a. State 10b. County	 	10c. City, Tov	vn or Locatio	on					10d. Inside City Limits
*		Maryland Cec	. 1	F1b	ton						1 Yes 2 X No
Maryland 28a-f show	용	Maryland Cec 10e. Street and Number	<u> 11</u>	LILK	1011	10f. Zip Co	de		10	g. Citizen of What Co	ountry?
645 ith the Maryland 23a or 28a-f shore.	Director	54 Greenwood S	treet			219	21			United S	tates
Victory with the response of t	eral	11. Marital Status	12. Was Deceder						pecify Yes or No-		erican Indian, Black,
ritem	Fune	1 Never Married 2	Married Armed Forces	s? 2 X No	If Ye	es, specify C	uban, Mex	kican, Puerto	Rican, etc.)	White, etc	
after al", o	by F		vorced If Yes, Give Year or Dates:			Yes 2 X					hite
hours natur	g	15. Decedent's Education (Sp						Give kind of NOT use ret		16b. Kind of Busines	ss/Industry
36 in 72 han "; lical l	ompleted	Elementary/Secondary (0-12) College (1-4 o	r 5+)	Nonn	. **				Child	Caro
withingiene	шо	7 17. Father's Name (First, Middle	e Last)		Nann	ı y	18.M	other's Name	e (First, Middle, M		Care
e filectal Hyked of	Be C	Sam Keene	-,,				Ma	ary Ho	naker		
212 buld b Meni mari	0	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (ber, City or Town, St	ate, Zip Code)
MD 12 sho th and 27 is	•	Tina M. Sheets	s/Daughter		54 Gr	eenwo	od St	reet,		MD 2192	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours al nt of Fealth and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal from S	1	e of Disposi natory or oth		of cemeter	ry, A116	gust 11,	20c. Location - City	or Town, State
MOI Pages ent of int: I		4 Departion 5 Other	Specify:	R. A.	Ferris	s & Co.	, Inc.	200)8	West C	hester, PA
Baltimore, MD 21215-0036 July Compensation of the American Security of the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee		22. N	ame and Ad	dress of F	acility Fur	nerals	РΔ	
C Pe C		21. Signature of Funeral Service 23a. Part I. Enter the disease, of	8- tuels		10	3 W. S	tock	ton St	reet E	lkton. MD	21921
Physician Medical		23a. Part I. Enter the disease, of failure. List only one caus	or complications that cause e on each line.	ed the death. Do	o not enter th	e mode of d	ying, such	as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
wedicai ∠xaminer		Immediate Cause (Final diseas or condition resulting in death)			hmia a	ıssoci	ated	with	cardiome	galy	Death
			Due to (or as a cor	isequence of):							
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of):							
	Examine	cause. Enter Underlying Caus (Disease or injury that initiated	c.	sequence of):							
nted d ansit		events resulting in death) Last	d ,								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Medical	XX UNPENDED	AMENDED 2:	3a,2/,p	erME,g	3883 9	/5/08	3 TT	-		
760, icate be physic the burn	Med	IF FEMALE:		come of pregnar	псу				**	23d. Date of deli	
687 ertific ding p	_	23b. Was decedent pregnant in past 12 months?	December 1	at time of death	_ =			ctopic pregn	ancy	Month	Day Year
Box 687 he death certifi the attending	Physicia	1 Yes 2 No 9 🗸 U			5 Ott	her (Specify)				
D. E trithe d by the		Part II. Other significant cond			Ilting in the u	ınderlying ca	use given	in Part i.	23e. Did to	bacco use contribute	e to the cause of death?
ires that the signed by the detached	b b								1 Yes	2 No 3 1	Probably 4 🗸 Unknown
cords, law require has been si	Completed								24a. Was autop		e autopsy findings available to completion of cause of
e law e has ge 2 sl	直		·							med? deat	h?
ital Rec ician: The la s certificate h	ပိ	25. Was case referred to media	cal			26	Place of E	Death (Check		2	100 2 10
Vita hysicia this cer ul direct	o Be	examiner? 1 ✓ Yes 2 No	Observation of the Company	atient 2 El	R/Outpatient	3 DO	Oth	er Nurs	ing Home 5	Residence 6 🗸 0	ther: Scene
ing Phyling Ph	⊢	27. Manner of Death	28a. Date of I (Month, Da	njury 28	8b. Time of I	njury 28	. Injury at	Work?	28d. Describe	how injury occurred	
ion tendin eath. lor: /	턃		nding vestigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes	2 No			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. For the prince of the this certificate has been signed by filled in by the funeral director, page 2 should be detach	iji	3 Suicide 6 Co	ould not be 28e. Place of	f Injury - At hom	e, farm, stree	et, factory, o	ffice buildi	ing, etc.	28f. Location (r Rural Route Number, City
DIVI Hospital or 24 hours after Funeral Dir	Certification:	4 Homicide	termined (Specify)							<u> </u>	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	gal	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best of caminer:On the basis of e	f my knowledge,	death occur	red at the ti	ne, date a	and place, an	d due to the caus	se(s) and manner as and place, and due to	stated. to the cause(s)
To d withi To d	Medical	29b. Signature and title of cert	and manner state	ed.			icense nu				(Month, Day, Year)
	2	1	, Mos				D.C.M.E			August 8, 200	
		30. Name and address of pers		of death (Itam 31	3a)						
			on who completed cause of tant Medical Examir		enn Stree	et, Baltim	ore, MD	21201			
s	tate	<u> </u>	- 00	trar's Signature		100		-			
S	tate	31. Date filed (Month, Day, Yea	7 2008 32. egis	trar's Signature	Land	100					

State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Η. Moser 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kegiona Wicomico Center If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs Director 185-24-2403 10-7-1929 78 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No PA Berks Reading 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 Perkiomen Avenue 19606 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No 1948— If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No ģ Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 1950 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Inventory Control Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Herbert Moser Dietrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Donna J. Moser - Wife</u> Perkiomen Avenue, Reading, PA 19606 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If II any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🖫 Removal from State 4 Donation 5 Other (Specify) 8-2-2008 Forest Hills Mem. Pk.: Reading, Pennsylvania 21. Signature of Funeral Service Licepsee 22. Name and Address of Facility Bounds Funeral Home Hervy 705 E. Main Street, Salisbury, MD 21804 23a. Paul I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WTRACEREBRAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it as a solid to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consectionne of) Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the a 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this nortifier. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signatury on who completed cause of death (Item 23a) (Type, Print) SHOW HILL RD PICKL M.O. ar's Signature 3 Registrar

903 - 3

Maryland 21215-003

Baltimore,

Division of Vital Records, P.O. Box 68760,

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 4 2008

32. Registrar's Signatu

P.O. Box 68760, of Vital Records, certificate **Division**

2. Date of Death August 1, 2008 1:30 A Middleton J. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potamac Manor Care of Potomac 8. Date of Birth (Month, Day, Year 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min 1 XXM 2 ☐ F 75 July 22, Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-... any injury or other traumatic event. 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Prince George's Forestville 10f. Zip Code 10g. Citizen of What Country? 6606 Nyack Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 273 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Completed by 1 ☐ Yes 2 KNO Specify. White Specify: 3 Widowed 4 XXDivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Repairman D.C. General Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Roland Middleton F., C_{OX} Ruth ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Middleton / Son 109 Weatherby Court Lexington, South Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 8/8/2008 Cedar Hill Cemetery Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA of Funeral Service Licensee also 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complica ons' that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only 1RRHOSIL Immediate Cause (Final disease or condition resulting in death) **Physician** ZHINOM /Medical Due to (or as a consequence of) Examiner FAILURE HEARS (ONGESTIVE YEARC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed CARDIO VAI CULAR DUMBA ATHERUSCLEROMC Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> MELLITU(MIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2**4.4**No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 XXNursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 KNNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral. 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation XX Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1140216 Df 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD8188 Oxon Hill Road #704 Oxon Hill, Maryland 20745 Dennia A. Cullen 31. Date filed (Month, Day, Year) 32. Registrar's Sign State AUG 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

465-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 28, 2008 **Physician** 9:00 P_M George Ellsworth Nash, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's 8815 Hawthorne Lane #201 Laure1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec 24, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√XM 2□ F Months Days Hours 1929 Washington DC 78 578 44 2707 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evanities must be notified at once. Director 1 Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 United States 8815 Hawthorne Lane #201 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 12 Yes 2 □ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 à If Yes, Give Korean 1 ☐ Yes 2/No Specify White Specify: 3 X Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Glass- Windows <u>Glazier</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ellsworth Nash, Sr. Margaret C. Byrne ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanette Davis (Daughter) 3925 Saxton Court, White Plains, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Kurial 2 ☐ Cremation 3 Removal from State ₹ort Lincoln Cemetery Aug 1, 2008 Brentwood, MD 4 ☐ Donation 5 ☐ Q 21. Signature of Functal Service Lig 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. P. 11. Enter the disease, or court cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Up 17.7 one cause on each line. Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 🗌 Yes 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2010 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home XX Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 29c License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

M#103 FT. WALLighten

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 10 2008 ar 12:20 PM Louellen Vrahiotes Powell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Homewood at Crumland Farms Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖫 F 578-22-6690 83 Yrs Director May 24, 1925 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the first Experient must on notified at Maryland Frederick Frederick 1 ☐ Yes 🎾 No Director 10f. Zip Code 10g. Citizen of What Country? 7401 Willow Road, Apt. 215 21702 U.S.A. Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 21 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aristides Vrahiotes Mary George ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Item 27 is 1 Albert M. Powell, M.D., husband 7401 Willow Road, Apt. 215, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1X Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Aug. 13, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) eral Service Licensee 21. Signature of Fp R. Name and Address of Facility Keeney and Basford PA Funeral Home Rich MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trensi and Due to (or as a consequence of) physician a the burial-Box 68760, The law requires that the death certificate be Physician/Medical ettending | IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy õ Year Month Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) signed by the e detached o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy After this certificate funeral director, pag 2 No 1 ☐ Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Division To the Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after down...

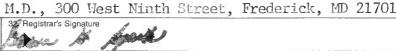
To the Funeral Director: After a second of the funeral director. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) AUG 15

Ali J. Afrookteh,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10

D 35183

August 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26428

	1- For State Certification Cer	ificate of Death	Reg. No.	
Physician	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death
al Examine	Michael Anthony Roncarati 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 9, 2008 4c. County of Death	0615 hrs
> .	163 Allendale Drive	Aberdeen	Harford	'
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24Hrs		
Director	222-60-9965 1XXM 2 F 41	Yrs. Months Days Hours Min.	March 2, 1967	ountry) PA
	Usual Residence of Decedent			
w any		own or Location		10d. Inside City Limits 1 X Yes 2 No
yland yland f sho	Delaware New Castle	Newark	10g. Citizen of What Cou	
the Maryland as or 28a-f show tiffed at once.	Toe. Street and Number	·		ntry?
1264th death with the Maryland or items 23a or 28a-7 sho must be notified at once		. 13. Was Decedent of Hispanic Origin? (Sp	uSA pecify Yes or No- 14, Race - Amer	ican Indian, Black,
r death with or items 23	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
s after of rall", on niner m	1 3 Midowed 4 V Divorced III Yes Give Year	1 Yes 2 X No specify:	Specify: Whi	te
hours natur Exami	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of videning most of working life. DO NOT use reting the control of the control		Industry
5-0036 ed within 72 hour lygiene. other than "natu be Medic I Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	laborer		
5-0036 led within 72 tygiene. other than he Medical	12 0		(First, Middle, Maiden Surname)	
b 21215-0036 2 LQ LL should be filled within 72 hours after death with the Maryland and Mental Hygiene, 17 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once TO Be Compulated by European Director		Maryan	ne M. Namiotkiew	ricz
D 21 hould hould and Men is man		19b. Mailing Address (Street and Number or F		e, Zip Code)
M 2 dalah M 2 M 2 M 2 M 2 M 3 M 3 M 3 M 3 M 3 M 3	Maryanne Menghi (mother) 20a. Method of Disposition 20b. Pi	209 Sleepy Hollow C ace of Disposition (Name of cemetery,	t., Newark, DE 197 Date 20c. Location - City o	11
Baltimore, permit. Pages I an Department of Her Important: If ite		ematory or other place)		
Baltimo permit. Page Department of Important: injury or ott			6/08 Port Depos	
Balt permit Depart Impor	21. Sign but Funds Service Iconsee	22. Name and Address of Facility Aberdeen, Maryland	arring-Cargo Funer	al Home, P.A.
Physician	23a. Part I. Enter the disease, or complications that caused the death. I			Approximate Interval
Medical	fallure. List only one cause on each line. Immediate Cause (Final disease a. ALcohol & narc	otic (methadone) intox	rication & cocaine	Between Onset and Death
_xaminer	or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ed Insit	cause. Enter Underlying Cause (Disease or injury that initiated			
ted Insit	events resulting in death) Last Due to (or as a consequence of):	:		
760, cate be executed physician and the burial - transit	X UNPENDED AMENDED 23a,27,2	8a-f, perME, g882 8/22	2/08 TT	
ion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be exect leath. After this certificate has been signed by the attending physician an the funeral director, page 2 should be detached for use as the burial or after the Computation by Device is an after the after the Computation by Device is an after the after the Computation by Device is an after the after the computation by Device is an after the after the computation by Device is an after the computation by the Device is an after the computation of the co	IF FEMALE: 23c. If yes, outcome of pregna		23d. Date of delive	гу
687 certific ding p	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	ancy Month	Day Year
the death certification by the attending picked for use as the Driversian	1 Yes 2 No 9 Unknown	th 5 Other (Specify)		
P.O. Es that the gned by the detached		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires that signed			1 Yes 2 No 3 Pro	bably 4 🗸 Unknown
w requi				utopsy findings available completion of cause of
of Vital Records, ig Physician: The law requires ther this certificate has been signered director, page 2 should be at To Be Compileted.		-	performed? death?	es 2 No
ician: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check	only one)	
of Vit ing Physic After this uneral dir	1 Yes 2 No Inpatient 2 E		ng Home 5 Residence 6 V Other	er: Scene
in of Nating Ph. h. : After the funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred unk	
Division tal or Attendi rs after death. al Director: A led in by the fu	2 Accident Investigation Fnd 8/9/08 28e, Place of Injury - At hor	Fnd 6:00 atm me, farm, street, factory, office building, etc.		tural Route Number, City
Division of spital or Attending tours after death. neral Director: After filled in by the functions.	3 Suicide 6 X Could not be determined (Specify) found	in vehicle	28f. Location (Street and Number of R or Town, State) 163 ATT Aberdeen, MD	endale Dr.
0	29a Lentiter			
To the H within 24 To the Fu	one) 2 Medical Examiner: On the basis of examination and manner stated.			
	29b. Signature and title of certifier	29c. License number	ME 29d. Date signed (M	onth, Day, Year)
	I hoder We King The	NO O.C.M.E.	August 9, 2008	
	30. Name and address of person who completed callse of death (lifem 2 Theodore M. King, Jr., MD. Assistant Medical Ex		e, MD 21201	
Stat		e		
Registra		Rocall .		

ORIGINAL

			For State Registrar	•	rtment of Health and N <i>tificate of Death</i>		ne No.2008	26429			
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death			
	/Medic		Lucille	Williams	Raynor	July :	28 2008	10:49 PM			
	Examin	er	4a. Facility Name (If not institution, give street ar Frederick Memorial H	, , , , , , , , , , , , , , , , , , ,	4b. City, Town, or Location of Death		4c. County of Death				
J	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick 9. Birthpl	ace (State or Foreign try)			
	Director		127-26-0225 10M24	F 79 Yrs.	Months Days Hours Min.	SEPT 15	(Month, Day, Year) Country) (FI 15 1920 MISSISSIPPI				
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loc	cation		10	d. Inside City Limits			
	Maryla f sho	ō	MD. FREDERICK					1 Yes 2 No			
	r 28a	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?			
	th with 23a o ist be		104 ANDOVER	COURT	21702		U.S. A.				
9500	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Moden Evant or must be midffed at	by Funeral	1 Never Married 2 Married 1 If Ye	Yes 2. No	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I □Yes 2☑No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.			
0-6171	vithin 72 ho ene. than "natur e Modical I	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12)	eted) (Give life, L	dent's Usual Occupation kind of work done during most of work DO NOT use retired) AL WORKER	ing 16th	o. Kind of Business/Ind	w york			
7 0	be filed v ntal Hygic d other i event, th		17. Father's Name (First, Middle, Last)	300		e (First, Middle, Mai	den Surname)				
au		To Be	TOMMY WILLI	4ms	l l	- REDA	•				
ary	2 should I and Men is marke aumatic	-	40- lefe	1 401 14 7	ng Address (Street and Number or Run						
Σ,	27 27		TOYCE RAYNOR HEN	Ry(000) 224	SHANNONBROOK						
Saltimore	Page: nent o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	FAIR VIEW	natory or other place) Com. Aug 2	,2008 /	. Location - City or Tov	K MD.			
Dall	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licenses) Sury A. //	leis 11	Name and Address of Facility 67	PRY L. TO	ica mo	ten Ifene 4701			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or him failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	on each line.	er the mode of dying, such as cardiac		A A	Approximate Interval Between Onset and Death			
eu,	tificate be executed g physician and as the burial-transit	al Examiner	if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	le to (or as a consequence of):							
09/90	ficate phys the	edical	d								
O. Box	sician: The law requires that the cleath certific certificate has been signed by the attenting prector, page 2 should be detached for use as	sician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Ye ar			
cords, P	quires that en signed b uld be deta	ed by Phys	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to th	e cause of death?			
ď)	The law re ate has bee page 2 sho	Completed				24a. Was an autopsy performed 1 □ Yes 2 ♣	prior to cor death?	osy findings available appletion of cause of			
N Ea	cian: ertific	Be (25. Was case referred to medical examiner?			h (Check only one)					
0	Physical direction	70	1 ☐ Yes 2 ☐ No Hospital: 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpatien Date of Injury 28b. Time of			e 6 Other (Specify)			
	iding th. After funer	tion		(Month, Day, Year)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred				
DIVISION OF	I or Atten after deal Director: I in by the	Certification:	© □ Could not be	Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,			
	To the Hospital or Attending Physician: The I within E4 horurs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: On and	To the best of my knowledge, death the basis of examination and/or in manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)			
	To th within To th comp	Me	29b. Signature and tive of certifier	MD.	29c. License number D 3 4-30	3 29d	Date signed (Month,	Day, Year) 2008			
•	9		30. Name and address of person who completed IRFAN W. HASSEN	cause of death (Item 23a) (Type,	Print) USE AVE, FRED	ERICK,	Md. 21	70/			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1 2008	32. Figistrar's Signature	29c. License number D 3 F 30 Print) USE AVE, FRED	· · · · · · · · · · · · · · · · · · ·					

			1 - For State Registrar	State of Maryla			f Health a of Death		F	Reg. No.	008	3 2	6430
	Physici /Medi		Decedent's Name (First, Middle, La. ELIZABETH CLAIRE	,				*	2. Date of Dea Month Jul	y Day 2	4, ^{Year}	3. Tir	ne of Death 4 PM
	Examir		4a. Facility Name (If not institution, giv 2009 Owens Road			Oxon				4c. Co Pri	nce (George	
	Funeral Director		5. Social Security Number 6. S 138-12-2715	ex	s. last birthday) 7 Yrs.	If Under 1 You Months Da		Min.	B. Date of Birt (Month, Day April 2	, Year) 2, 19	21 N	rthplace (Si Country) Iew Je	rsey
	e Maryland 8e-f show tiffed at	ctor	10a. State 10b. County	_	City, Town or Lo							1 🗆	de City Limits
	with the	Dire	10e. Street and Number 6009 Woodmont Roa	a d		10f. Zip Coo				10g. Citizer		Country?	
980	n 72 hours after death with the Maryland "netural", or Items 23a or 28e-1 show calcal Expenient or ust be mailined at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:	U.S. 13.		of Hispanic Ori Cuban, Mexican	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14.	Race - Am Black, Wh	erican India ite, etc. White	
21215-0036	c * *	Completed by	15. Decedent's E. (Specify only highest grade	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Oo kind of work do DO NOT use re Maker	one during mos atired)	t of working	7		of Busines Resid	·	
Maryland 2	nit. Pages 1 and 2 should be filed within ratment of Health and Mental Hygiene. ortent: If item 27 Is marked other than "injury or other traumatic event, ITe Mage.	To Be Co	17. Father's Name (First, Middle, Last, Thomas Nally					ers Name (First, Middle,	Maiden Su	mame)		
	and 2 sho valth and n 27 Is m er traum		19a. Informant's Name/Relationship (Richard Regensbur	**			reet and Numbe nt Road		Route Numbe Alexan				22307
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, crei	matory`or other	place)	uly 3	te 1, 200			r Town, Sta	_{te} Virgini
Balti	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Licer	well			ddress of Facilit		RLY FU Fairfa				
	ate be executed // Medical number // Medical num	dical Examiner	23a. Part. Enter he disease of comshock, or hear failure. List only Immediate Causa Final disease or condition resulting in death) Sequentially list conditions. Tay leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	ruke equence of): aquence of):							Interva Onset	and Death
.O. Box 68	death certific e attending p d for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	tal death 3	Ectopic pregn				230	. Date of d Month	elivery Day	Year
Δ.	w requires that the been signed by the should be detache		Part II. Other significant conditions of	contributing to death but not r	esulting in the u	nderlying cause	e given in Part I	•		obacco use			e of death?
Division of Vital Records,	The law ate has b page 2 si	Completed									44b. Were a prior to death?	completion	lings available to of cause of
of Vita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		☐ ER/Outpatier		Other: 4 🗆 Nu	rsing Hom	Check only o	lence 6		ecity) (+c	spice
ision	Attending I r death. ector: After by the funer	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e Con Diago of Injury At		M	Injury at Work? 1 Yes 2	No	3d. Describe h			Rural Route	Number.
Div	pital or A ours after lerel Dire		4 Homicide determined	building, etc. (Spe	cify)				City or Tow	vn. State)			
	thin 24 h	Medical		niner: On the basis of exami and manner stated.	nation and/or in	vestigation, in r	my opinion, dea	th occurre	at the time,	date and pla	ace, and de	ue to the ca	
6			> Jhuffyl	Story M	O	Old	010550	063		7/:	18/0	8	
			8316 AVIV	completed cause of death (In	d. #	Print)	Fairfo	AX,	VA	220		Bradfo Pontz,	ord S.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) ALIG 1 20	32 Registrar's Sig	nature	and to							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26431 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy K. Ryan July 29, 2008 6:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 27162 Barwick Drive Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 218-54-2188 1 □ M 2 🕅 F Months Days Hours Min. 95 Director 3/15/1913 Marvland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director Maryland Wicomico 1 XYes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27162 Barwick Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify à Specify. white 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker domestic 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Kimble Sr. Mary Eshleman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Tilghman/daughter 27162 Barwick Dr., Salsibury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 8/1/08 Port Deposit, MD 21. Signature of Furneral Service Licenses 22. Name and Address of Facility HOILOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ungerme their disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner d any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate Vital 1 □ Yes 2 No 2 □ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Yes 2 No Division of Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manper of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the Hospital Community within 24 hours after death.

To the Funeral Director: After the Funeral Director of the further fur 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month),

1206

Dr Suite 101 Sales!

rson who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

and -

08-05528 Ida Resnik Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 26432

		- For State	Certificate of Death							Reg. No.				- 0 7 0	
Physicia	_	1. Decedent's Name (Fi	rst, Middle,Last)								Date of Death Month	Day Y	ear/	3. Time of Dea	
edical Examir		Ida		<u>Resnik</u>			4b. City, To		antion of I		July 19, 20		ty of Deat		
7		4a. Facility Name (if not Laurel Regiona		street and numi	ber)		Laurel	WIT, OF LO	Cauonon	Deali			Georg		
	4	5. Social Security Numb		7	. Age (In yrs. I	ast hirthday)	If Under	1 Year	If Under	24Hrs. 8	B. Date of Birth	n(MM/DD/YY	YY) 9. Bi	rthplace (State o	or .
Funeral Director		156-01-74	39 1	M 2X F	89	Yrs	Months	Days	Hours	Min.	May 3.	1919	Forei	ountry New Jers	sey
any		Usual Residence of Dec 10a. State 10b	. County		10c. City	, Town or Local	tion							10d. Inside Ci	ity Limits
≥ .		MD H	loward		Co1	umbia								1 X Yes 2	2No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Numbe				- Camb La	10f, Zip 0	Code			10	g. Citizen of	What Cou	untry?	
the M	ä	6336 Ceda	ır Lane				210					U.S.A			
DUAT death with the Maryland or items 23a or 28a-f sho must be notified at once.	era	11. Mantal Status		12. Was Dece		l.S. 13. W	as Deceden Yes, specify	t of Hispa Cuban, N	anıc Origir Mexican, F	n? (Spec Puerto Ri	ify Yes or No- can, etc.)		ace - Ame /hite, etc.	erican Indian, Bla	ack,
or ite	Funeral	1 Never Married		1 Yes	2 X No		Yes 2	7 No	enecific			Speci	iy: Whi	te	
s after	2	3 X Widowed 15. Decedent's Educa		If Yes, Give Year or Dates:	completed)	16a, Decede	nt's Usual C	ccupatio	n (Give ki	nd of wor	k done	16b. Kind of			
"natu	eted	Elementary/Seconda		College (1-		- during n	nost of work	ing life. D	DO NOT u	ise retired	d)				
1215-0036 d be filed within 72 fental Hygiene, narked other than event, the Medical	힐	12				Desig	n Cons							allpaper	
5-00 ed wit fygien other	Comple	17. Father's Name (Fire	st, Middle, Last)					18	3.Mother's	Name (F	irst, Middle, N	Maiden Surna	ime)		1
2121: ould be fill I Mental I- is marked ic event,	8	Hyman Wei				AOh Mallin	- Addross	(Chront	Bess	ie (Unknow	n)	Town Sta	ate, Zip Code)	0906
AD 21215-0036 2 should be filed within 72 hours after hand Mental Hygene. 27 is marked other than "natural", of martic event, the Medical Examiner.	မိ	19a. Informant's Name. Syde1 Che			. 22		N. Le							er Sprin	1
, MD and 2 sho ealth and em 27 is	-	20a. Method of Dispos		Daugnte		Place of Dispo	sition (Nam				Date	20c. Locati	ion - City	or Town, State	
Baltimore, MD 21215-003 permit, Pages I and 2 should be filed within perpetrient of Health and Moulal Hygiene. Important: If tiem 27 is masked other if injury av other traumatic event, the Med		1 X Burial 2	Cremation 3	X Removal fro	m State	crematory or o		O.T.		7/22/	2008	News	rk 1	New Jers	sev
Iti. Pa it. Pa rtmen ortant	. 11.0	4 Donation 5 21. Signature of Funer	Other Specify:	see .	GO						Memoria				-
Ba perm Depa Imp	i	12	18	4		11.1	70 Ro	ckvi	lle	Pike	Rocky	ville.	MD .	20852	
Physician		23a. Part I. Enter the d	isease, or comp	lications that ca	used the deat	h. Do not enter	the mode o	f dying, s	uch as ca	ardiac or r	respiratory arr	est, shock, o	r heart	Between C	Onset and
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ammer		or condition resulting i	n death)	Due to (or as a	consequence	of):									-
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77	Examiner	cause. Enter Underlyi (Disease or injury that	ng Cause c. initiated c.	Due to (or as a	oonooguango	of):									
2 bar insit	Exa	events resulting in dea	ath) Last d.	•											
760, cate be executed physician and the burial - transit	ical	X UNPENDED		AMENDED	238,27	,16a-b, ,pemE,	20a-b	9/12	7FH (3882 TT	8/18/0)8 TT			
60, ate be ohysici	Medical	IF FEMALE:			outcome of pre	egnancy						23d. Da	ate of deliv	-	Year
OX 687 eath certific attending p	an/	23b. Was decedent pre past 12 months?	egnant in the	1 Live b	irth ant at time of	1 41 ==================================	Fetal death		Ectopic	pregnan	icy	Mon	ıtn	Day	Teal
Box 687 death certifine the attending ed for use as t	Physici	1 Yes 2 ✔ No	9 Unknow	-		5	Other (Spe	спу)							
that the denoted by the		Part II. Other signific	ant conditions	contributing to	death but no	t resulting in the	e underlying	cause g	iven in Pa	art I.				to the cause of	
P.O. res that t	d by													Probably 4	
ords, P w requires t s been sign should be c	Completed										24a. Was	psy	24b. were prior death	autopsy finding to completion of	f cause of
eco he law ate has	l mo										1 Yes	ormed? 2 No	1		No
tal Rec clan: The certificate ector, page	Be	25. Was case referred							of Death						
Vita hysich this co	0	examiner? 1 ✓ Yes 2				✓ ER/Outpatie					Home 5	Residence		ther:	
n of Nding Ph. After t		27. Manner of Death 1 X Natural		28a. Date (Month	of Injury ı, Day,Year)	28b. Time o	of Injury		ry at Work res 2	,	200. Describe	e now injury c	recuired		
ivisior or Attend after death Director:	äŧ	2 Accident	5 Pending Investigation	tion 280 Bloc	o of Injune. At	t home, farm, st	reet factor				28f. Location	(Street and I	Number o	r Rural Route No	umber, City
Division of Vital Records, tal or Attending Physician: The law requints after death. The three of After this certificate has been so he in by the funeral director, page 2 should the lin by the funeral director, page 2 should the tall of tall of tall of tall of tall of tall of tall of tall of tall of tall of tall of tall of tall of tall of	Certification:	3 Suicide	Could no determine	be		t nome, ram, s	acci, iactor	y, 011100 D	anding, o		or Town,	State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		4 Homicide 29a. Certifier	ertifying Physic	Jan. Ta tha had	at of my knowl	edge, death oc	curred at the	e time, da	ate and pla	ace, and	due to the car	use(s) and m	anner as	stated.	
To the F within 24 To the F	Medical	(Check only one) 2 M	ertifying Physic edical Examine	er:On the basis and manners	of examination	n and/or investi	gation, in m	y opinion	, death o	ccurred a	t the time, dat	e and place,	and due t	to the cause(s)	
S Witt	Ne.	29b. Signature and tit	le of certifier	and manner e			29		e number	OCA	ЛE	1	-	(Month, Day, Yea	ar)
		Theod.	111-	16-00	The se	u)		O.C.	M.E.			July 20	0, 2008 		
		30. Name and address					444.0	one Ct	roet D	altimor	e, MD 2120	71			
		Theodore M.				l Examiner		enn St	reet, Da	atuttiOfe	5, IVID 2 121				
	State	31. Date filed (Month.	Day Year)	102	egistrar's Sigr	lature	set !								

			1- For State Registr A mended item#	State of Maryland / Department 20b, Date, 20c, $SLU C^{e}$				33
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of I	Death
	Physicia /Medic		JOSEPH D. 5	AUSBers			5 2008 843	AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	
			PhychoRAGE NURS	ELL & BEHAB	SALISBURY		Wicomico	
	Funeral		Social Security Number 6. Sex	W 005	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birthplace (State or Country)	Foreign
ı.	Director		796-34-3117	M 2LIF 79 Yrs.		June 19,	1939 NC	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City	y Limits
	f ehc	0	MD WOO	mico Salis	bund		1 🗹 Yes	2 🗌 No
	the 1	Director	10e. Street and Number	Trice Dating	10f. Zip Code	10g	. Citizen of What Country?	
	3a or	ā		Ior Mill Rd.	21801		U.S.A.	
	deeth with the Maryland tme 23s or 28s-f ehow ir metal be polified at	Funeral		2. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Si	pecify Yes or No-	14. Race - American Indian,	
٥	or its		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerti	Hican, etc.)	Black, White, etc.	
2-003p	s within 72 hours after deeth with the Marylan jiene. r than "natural", or Itame 23e or 28e-f ehow the Modical Examirat mast be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø No Specify:		Specify: Black	
ה	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece	dent's Usual Occupation kind of work done during most of wor. DO NOT use retired)	king	b. Kind of Business/Industry	
Z	within ene. then "	idu	Elementary/Secondary (0-12)	College (1-4or 5+)			Salisbury	
Z	Hygien Sthertl		17 Sathada Nama (Sint Middle Last)		ustodian		Steel Co.	
	a ta b e	Be	17. Father's Name (First, Middle, Last)	1 (0 10		ne (First, Middle, Ma	Gen Sumame)	
2	should nd Men marke umatic	٩	19a, Informant's Name/Relationship (Tys	ood Saunder			China Tana State 7to Code	
Z Z	d 2 st th and 7 ts n traur				ng Address (Street and Number or Ru			~ 1
o,	ges 1 end 2 should it of Health and Mer if Item 27 is marke or other traumatic		Sharon Saund 20a. Method of Disposition	20b. Place of Dispo	99 Naylor Mill sistion (Name of		c. Location - City or Town, State	301
more,	ages nt of nt of nor or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State Difect, Ca	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Date 20 7/08 D	over. DE	
	artme ortani		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Paginal Service License		2. Name and Address of Facility		All W. Isabella St	
Balt	permit. Peges 1 Department of H Important: If Ite ony Injury or ot		MONTE	. ()	ennie Smith Funer			
			23a. Part1. Enter the disease, or complic	cations that caused the death. Do not ent			. Approximate	3
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Aswn		Interval Betwonset and D	Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	77 300 1)		54cm	7
	Examiner							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	nd nd transi	Examiner	Cause (Disease or injury that initiated events					
Š	be executed iclen and burial-transit	Ë	resulting in death) Last	Due to (or as a consequence of):				
8/PU	ate hys	dicai	d					
o ×	leath certifica ettending ph f for use as ti	0	IF FEMALE:	3c. If yes, outcome of pregnancy			T	
Š Q	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal death 3☐	Ectopic pregnancy		23d. Date of delivery Month Day Y	'ear
o	the de	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)			
7	wrequires that the death certific been signed by the ettending p should be detached for use as		Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of de	eath?
cords,	quires n sign ald be	d by				1 ☐ Yes	2 No 3 Probably 4 U	Inknown
င္ပ	> 0 0	ete				24a. Was an	24b. Were autopsy findings a	available
ě	0 - 0	Completed				autopsy	prior to completion of ca d? death?	ause of
VII A	sician: The certificate rector, pag	0	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	YNo 1 ☐ Yes 2 ☐ No	
<u> </u>	Physiclan: this certific ral director,	To B	examiner? 1 Tes 2 No	ospital:			e 6 □Other (Specify)	
0	ding Phys th. After this funeral dir		27. Manner of Death	28a. Date of Injury 28b. Time o		28d. Describe how		
0	ttendir death. tor: Af the fu	atic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	[, ==, :==,	M 1 ☐ Yes 2 ☐ No			
DIVISION	r Att	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Numb State)	ber,
	Ital or rel D led ir	O						
2		60	29a. Certifier Certifying Physical Check only 2 Medical Examin	ician: To the best of my knowledge death	n secured at the time, date and place vestigation, in my opinion, death occu	and due to the daw rred at the time, date	so(s) and manner as stated and place, and due to the cause(s))
2	Hosp 24 hou Fune Hely fill	유	one)	and manner stated				
ב	o the Hosp ithin 24 hou o the Fune ampletely fil	Medical	one)	and manner stated.	29c. License number	29d	. Date signed (Month, Day, Year)	
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director.	Medic	one)					
)	To the Hosp within 24 hou To the Fune completely file	Medic	29b. Signature and title of certifier	DR-USHA NATUSAN	0057359		Date signed (Month, Day, Year) Jy 2515 2008	
3	To the Hosp within 24 hou To the Fune completely fill	Medic	29b. Signature and title of certifier When the signature and address of person who co	DR-CIS HA NATES AW mpleted cause of death (Item 23a) (Type,	00 57 35 9 Print)			
2	To the Hosp within 24 hou within 24 hou To the Fune Completely file	æ	29b. Signature and title of certifier When the signature and address of person who co	DR-CIS HA NATES AW mpleted cause of death (Item 23a) (Type,	00 57 35 9 Print)			

DHMH 17 Rev 1/2001

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State Registrar

AUG 0 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician Month 9 Regina 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Dorchest Combridge Vorchester General If Under 1 Year | If Under 24 Hrs.
Months Days Hours 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F 216-70-574 June 2, 1958 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Completed by Funeral Director ambridge Dorchester 10e. Street and Number 10g. Citizen of What Country? 21613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Health 10 Service Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lee Midgett D. Johnson Vonderine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909- Hubbard Street Cambridge, Maryland 21613 Benjamin Lamont Robinson Sharp 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/08 4 ☐ Donation 5 ☐ Other (Specify) rossivads Cemetery Vienna, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address Facility Henry Funeral Home, P.A. 510 washington St. Cambridge 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intravas Cular disseminated Coagulo Puth Physician Hours /Medical Due to (or as a consequence of) Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed preumonia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 disease lung 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Work MD Ahmed Doo65528 30/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Woib NO 3cc Byrn Sh

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0.1

32. Registrar's Signatu

MD

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Physician /Medica Examine uneral rector	n al	1. Decedent's Name (First, Middle, Last)	A .							
Examine uneral rector			A. SHENTO	N			2. Date of Demonstrate / / 2	6/2008	3 Year	3. Time of Death 8:30am M
Mo M		4a. Facility Name (If not institution, give Hertitage Harbour 5. Social Security Number 220-36-3928 Usual Residence of Decedent	Health & Reh	.ab s. last birthday) 8 Yrs.	4b. City, Town, or Anna; If Under 1 Year Months Days	Location of Deat	. 8. Date of Birt	Anr	nty of Death e Arun 9. Birthp	lace (State or Foreig
6.3		10a. State 10b. County		City, Town or Lo	cation				1	0d. Inside City Limits
28a-f s	Director	MD Anne Aru	inde1	Annapo				10.00		1 □Yes 🛣 N
3a or		146 Jefferson St.			10f. Zip Code	21403		-	of What Cour	itry?
8	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 □Yes 文文No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cuba l □Yes 2 1100		Specify Yes or No to Rican, etc.)	- 14.	Race - Americ Black, White, o	
is Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	turina most of wo	rking		of Business/łno	,
vent, I	Be C	17. Father's Name (First, Middle, Last)	<u>J</u> +	Educ	ator	18. Mother's Na	me (First, Middle,		lucatio name)	n
atice	0	Alexander W. Andre	Ws			Flora	Ethel No	well		
traum	ì	19a. Informant's Name/Relationship (Ty	· · · · · · · · · · · · · · · · · · ·		ng Address (Street		ural Route Numb	er, City or To	wn, State, Zip	Code)
any injury or other once.		Derwill Andrews 20a. Method of Disposition	Brother 20b.		Jeffersor sition (Name of natory or other place		Annapoli Date		21403 on - City or To	wn, State
Jury	-	¥ExBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	odfield	Cemetery	7/2	9/2008	Gales	ville,	MD
any in	ŀ	21. Signature of Funeral Service License	_	1	Name and Address 2 Ridgely	Ave. A	ardesty Annapoli		1 Home 21401	, P.A.
an cal		23a. Part T. Enter the disease, or doubli shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		TION !	PNEUMO		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
	₹I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome of preging 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy	/		23d.	Date of delive Month	ery Day Year
1	2	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to			ne cause of death?
	Completed		EMORRHAGE						4b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
å	0	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 [T EP/Outpation	t 3 🗆 DOA Othe		ath (Check only o		(Other 10 11	
F:00	- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	/ at	dome 5 Resident Resid			y)
Contification		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec				City or Tov	vn, State)		al Route Number,
Completely lilled in by the runeral director,	Medical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as s ce, and due to	stated. the cause(s)
	2	29b. Signature and title of certifier			29c. License			29d. Date si	gned (Month,	
de)	30. Name and address of person who co	mo			06753			7/28/1	08

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	/ Depa	rtment of H	Health and N		giene Reg. No.	8008	264	37
	Dhusisi		1. Decedent's Name (First, Middle, Last)			-		2. Date of De Month	ath Day	Year	3. Time of I	Death
	Physici /Medic		Geffrard L. S	axon				July	28,	2008	2022	М
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death		4c. (County of Death		
			Washington Advent			Takoma				ntgomery		
	Funeral		5. Social Security Number 6. Sex	in our	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or ntry)	
	Director		578-22-9126 Usual Residence of Decedent	83	115.			Sept.	3, 19	924 Wash	nington	, DC_
	land ow		10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City	y Limits
	Mary -f sh	to	MD Prince Ge	orge's Seat	Plea	sant					1X Yes	2 🗆 No
	7 28a	Director	10e. Street and Number	8-		10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	h with	Q IE	6511 Adak Street			20743			Unite	ed State	es	
	deat	Funeral	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto			4. Race - Ameri	can Indian,	
9	or Its		1 Never Married 2 Married	1 X Yes 2 ☐ No	-	☐ Yes 2 No		rnican, etc.)	}	Black, White, Specify: Bla		
9	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:		103 21110	эрвену.			эрөспу. Б12	1CK	
ry L	nati	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced (Give	ent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kin	d of Business/Ir	ndustry	
2	withir ane. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)					<u> </u>			,
2	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Itams 23a or 28a-f show ant, tre Maralcal Examirer must be mailfied at	ပိ	12 years 17. Father's Name (First, Middle, Last)		Uniei	System	18. Mother's Nam	e (First, Middle		Jernmeni		
au	od ta	To Be	Geffrard L. Saxon	. Sr.			Mary Ba	2		, , , , , , , , , , , , , , , , , , , ,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or liams 23a or 28a-f show any injury or other traumatic event, it is Marical Examination at the nutilities at once.	F	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street	and Number or Rui		er, City or	Town, State, Zi	Code)	
Ž	and 2 ealth a n 27 is		Shaaron R. Saxon	- Daughter		Adak Str			-	1D 20743		- 1
ē,	of Health of Health fitem 27 rother tr		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of patory or other place		Date		ation - City or T		
Ē	Pages nent of int: If it		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 3 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		-	ery Aug.	5. 200	8 511	itland.	Marvla	nd
aĦ	permit. Pag Department Important: any injury c		21. Signature of Funeral Service License		22.	Name and Addre	ss of Facility St	ewart F	unera	1 Home	Inc.	iru -
m	e de la constant		John J.	Stewart, I	/		ing Road,					
	**		23a. Part1 Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.	Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw	/een
	Physician		Immediate Cause (Final disease or condition	CARNION	ulm	DHARY	ARRE.	CT			Onset and D	eath
	/Medical		resulting in death)	Due to (or as a conseque		0.67(0-)	MCIC.	21				
L	Examiner		Sequentially list conditions	SEPTICE	=MI	A						_
	p ii	lner	Sequentially list conditions, if any, leading to unmediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a subseque	nce of).							
	and and I-tran	Examln	that initiated events resulting in death) Last	Due to (or as a conseque	noe of):							
8760,	cate be executed physician and the burial-transit	Ical E		Due to (or as a conseque	rice ory.							
687	icate phys s the	0										-
Вох	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance	у				2:	3d. Date of deliv	erv	
ğ	death i	ciar	in the past 12 months?	1 Live birth 2 Fetal d 4 Pregnant at time of dea		Ectopic pregnancy Other (specify) _	/		-	Month	-	ear
o.	at the de by the a	hys	9 Unknown	9□ Unknown								
ď.	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions con	tributing to death but not result	ing in the un	derlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to t	he cause of de	ath?
ğ	w require been sig should b							10	Yes 2.1≥	No 3 □ Pro	bably 4 □Ui	nknown
Hecords ,	aw as b	Completed						24a. Was		24b. Were auto	psy findings a	vailable
	9 4 9	E O							med?	death?	mpletion of ca 2 No	use of
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat					182
0	Phyaician: this certific ral director,	2	1 ☐ Yes 2 🕦 No	ospital: 1 ☑ Inpatient 2 ☐ EF	NOutpatient	3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	dence 6	□Other (Speci	fy)	
	ding P th. After t funera	.io	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe I	now injury	occurred		
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	o the	Med	29b. Signature and title of certifier	and the state of		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
	m s h ó		> dryphala N	D		MIL	(29		JULY		200	
1	(2)		30. Name and address of person who con	mpleted cause of death (Item 2	3a) (Type F	Print)	20-1					
1	9		VICTOR ONYEIL	9KA 7325AH	ARYDVE	RPARK	WAY GA	KEEPB	Cli	MARYL	myn 2	0770
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	Registr	ar	AUG 0 4 2000	TOWN A A	-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year John Joseph Stanislow July 31 2008 /Medical 7:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4/10/1920 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months **X**□M 2□F Days Hours 187-03-2692 88 PA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location fshow 10a, State 10d. Inside City Limits r 28a-f shov notified at Director 1 ☐ Yes 2 No MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be be "natural", or items 23a o 1 Duxbury Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Stanjslow John Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find and Mental His marked ot George Stanislow Anna Labuda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City on: Jown, State, Zip Code) Health a Claudia Jenkins / daughter 124 Rolling Rock Rd., Aiken, SC 29803 Injury or other nt of Hea : If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 Removal from State Department of Important: If any Injury or once, 4 ☐ Donation 5 Other (Specify) 8/4/2008 Sunset Memorial Park: Berlin, MD 21811 21. Signature of rvice License Burbage Funeral Home <u>108 William St., Berlin, MD 21811</u> 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALDIOVASCIALAR THEKDSLLERSTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 24a, Was an autopsy perform Physician: 25. Was case referred to redical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation Iniurv death. 1 ☐ Yes 2 ☐ No after death. 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

MA 6+1

State Registrar

ed (Month, Day, AUG 01

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

EASTERN SHORE OR SALISKURY Refistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2008

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Allen G. Siegel Ju₁y 29, 2008 12:30 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) May 19, 1934 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Hours Min. 1 M 2 □ F Illinois 74 353-26-9868 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Y⊟Yes 2□No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 U. S. A. 7505 Connecticut Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc 1X7Yes 2 No Army If Yes, Give Year or Dates:Korean 1 Never Married 2 Married White 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Law Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Morris David Siegel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 7505 Connecticut Avenue, Chevy Chase, Md, 20815 Rochelle R. Siegel - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Cemetery, crematory, or other place)
Garden of Remembrance
Memorial Park Date 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee Edward Sage Tacway Direction, Inc. 20852 1091 Rockville Pike, Rockville, Maryland ttottlemeer 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocorclical disease or condition resulting in death) Due to (or as a consequence of): Arley Disewe Atherosclevotiz COronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Benel Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 □Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Madical Eventure.

Baltimore, Maryland 21215-0036

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit certificate has

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Certification: To

29a. Certifier

P.O. Box 68760

funeral director, After this

oe /, Alleの ら、, Division of Vital Records, To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) Jy, 29,2008

d address in person who completed cause of death (Item 23a) (Type, Print) Bibuten Hospital 8600 old Georgetown Road Betherly, MD 20814 Strauss, MD

31. Date filed (Month, Day, Year) 0 1 AUG 2008 32/Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

			For State Registrar	State of Maryla		artment of F r <i>tificate of</i>			leg. No. 2008	3 26441
	Dhyciai	_	Decedent's Name (First, Middle, La	ast)				2. Date of Dea		3. Time of Death
	Physicia /Medic	al	MELVA FAYE	TAYLOR		4. 65. 7	- Landa of Dooth	July	30,200	3 8:20 AM
-	Examin Funeral Director		Social Security Number 6.	Street	s. last birthday) Yrs.	Glena:	r Location of Death rden If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan . 16	4c. County of Dea Prince Prince 9. Bir Co 1966 Was	George's thplace (State or Foreign punity) shingtonDC
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f sho	tor	MD Prince	George's Gl	lenarde	en				1 ☐ Yes 2 ☐ No
	th with the 23a or 28 ust be not	ral Director	10e. Street and Number 1401 Wesley St	reet		10f. Zip Code 20706	5	1	log. Citizen of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race · Ame Black, Whi Specify:	
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and	be file ntal Hy od othe event,	Be	17. Father's Name (First, Middle, Las	t)				·	Maiden Surname)	
Maryland	should nd Mer marke imatic	요	Donald Brown 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street		is Gree	ene r, City or Town, State,	Zip Code)
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Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery cre-	osition (Name of matory or other pla SS Crema	ce) atory8-5	I	20c. Location - City or Riverdal	
l Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	usca Tonuc					ONIC FUNE Waldorf,	RAL HOME P MD 20601
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_	uted 1 ansit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Court of the cause o	Due to (or as a cons	equence of):					
68760,	sician and burial-tra	edical Examiner	resulting in death) Last	Due to (or as a cons	equence of):					
	rtificate ng phy e as the		IF FEMALE:				9			
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rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions Morbid Obesit	•	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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	With Tot	Z	29b. Signature and title of certifier	1 Amount	/ MI	29c. Licens	se number	_ '	29d. Date signed (Mor	th, Day, Year)
۲			30. Name and address of person who	completed cause of death (if	19 / YK tem 23a) (Type:	Print)	リ メハ		11001	<i>υ</i> δ
	1.BZ		Dr Samuel (Carolino 758	32 Ann:	anolic I	Rd La	nham,	MD	
10 m	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1	2008 Segistrar's Sig	mature A	melle		,		

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

19a. Informant's Name/Relationship (Type. Print) Nelson Trout / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Chapel Place, Walkersville, MD 21793 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23a. Part. Inter the diseas of or complications in a falsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part. Inter the diseas of or complications in a falsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Chapel Place, Walkersville, MD 21793 25c. Location - City or Town, State 25c. Location - City o	d be filed ental Hyg ced other c event,	Be C	17. Father's Name (First, Middle, Last) John H. Peters	1		18. Mother's Name (F	irst, Middle, Maiden Thompson	Surname)						
22. Name and Address of Facility 23. Signature phrimaral Services Lorensee 24. Fulton Avenue, Walkersville, MD 21793 25. Particular to the stand for companions plated and the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest. 18. The median of Lorentz (Final Journal Services) 25. Particular to the stand of companions plated and the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest. 25. Particular to the stand of companions plated and the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest. 25. Particular to the stand of companions plated and the stand of	d 2 should th and Me 7 is mark traumatic	ř	19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Street	and Number or Rural R ice, Walkers	Noute Number, City of	or Town, State, 21793	Zip Code)					
22. Name and Address of Facility Stauffer Funeral Home 40 Fulton Avenue, Walkersville, MD 21793 23a Part Effect the deseary or complications (and pulsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Description Part Description Descript	Pages 1 an ent of Heal nt: If item 2 ry or other	3	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ref	20b. Pla	ace of Disposition (Name of metery, crematory or other pla	Date	20c. Lo	ocation - City or						
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Due to (or as a consequence of): Due to (or as a consequence of):			disease or condition resulting in death)	Due to (or as a consequent	ence of):	Chuir			Yenis					
FEMALE: 230. Was deceded pregnant in the past 12 menths? 1 Ves 2 Month Day Vear 1 Ves 2 Month D	uted Insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, unsease or moury	Due to (or as a consequent	ence of):									
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Figistrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 37. Date filed (Month, Day, Year) 38. Figistrar's Signature	this c		1 ☐ Yes 2 No	I 🗆 III patielit Z 🗆 E	R/Outpatient 3 DOA Otl	ner: Nursing Home	5 Residence	6 □Other (Spe	ecify)					
29a. Certifier (Check only one) 29b. Signature and title of certifier Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 State Registrar 31. Date filed (Month, Day, Year) 32. Figistrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Date filed (Month, Day, Year) 36. Signature and title of certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Figistrar's Signature	or: After he funera	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Accident Injury M 1 Yes 2 No											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 State Registrar 31. Date filed (Month, Day, Year) 2008 32. Figistrar's Signature	s after de al Direct ed in by t	Certific	3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 6 Could not be determined 5 Suicide 4 Homicide 6 City or Town, State 5 State 6 City or Town, State 6 City or Town, State 6 City or Town, State 6 City or Town, State 6 City or Town, State 7											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 State Registrar 31. Date filed (Month, Day, Year) 2008 32. Figistrar's Signature AUG 0 1 2008	in 24 hou he Funer pletely fill		(Check only 2 Medical Examin	er: On the basis of examinati	rledge, death occurred at the t on and/or investigation, in my	ime, date and place, and opinion, death occurred	d due to the cause(s) at the time, date and) and manner a d place, and du	s stated. e to the cause(s)					
Casper Cline, MD 300 West Ninth Street, Frederick, MD 21701 State Registrar AUG 01 2008 32. Figistrar's Signature H 17 Rev 1/2001	Tot	Ž	29b. Signature and title of certifier	1/2			29d. Dat	te signed (Mon	th, Day, Year)					
Registrar AUG 0 1 2008 Steen St. Aparts H 17 Rev 1/2001	10					rederick, M	D 21701							
H 17 Rev 1/2001			31. Date filed (Month, Day, Year) 1 20											
	H 17 Rev 1/20	001												

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exertment must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

	For State of Ma			rtment of H <i>tificate of L</i>		/lental Hy	'gien Reg. N	- 7 H	08	26443
	Decedent's Name (First, Middle, Last)					2. Date of De				3. Time of Death
an	Talan E Thansana					July 3		ay 2008	Year	11:50 A ^M
cal	John E. Thorpe 4a. Facility Name (If not institution, give street and number)		T	4b. City, Town, or	Location of Death	July J.	-	c. County	of Deat	
ier									~ C-	amaa!a
	Southern Maryland Hospita 5. Social Security Number 6. Sex 7. Age	L e (In yrs. last birt	thday)	Clinton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		g. Birt	eorge's
	1 🕅 M 2 🗆 F	,	Yrs.	Months Days	Hours Min.	Oct. 10	a <i>y, Y</i> ea		Co	cth Carolina
	578-50-2831	71				UCL. I	<u>ا و ا</u>	1930	NOI	th Carolina
	10a. State 10b. County	10c. City, Town	or Loc	cation						10d. Inside City Limits
ō		C	17							1 X Yes 2 □ No
Funeral Director	Maryland Prince George's	Seat P	теа	10f. Zip Code			10a. C	Ditizen of \	What Co	untry?
۵										
era	5735 Bugler Street	Ever in LLS	12 V	20743	ienanic Origina (Sp	acify Vas or No		ited		erican Indian,
ä	Armed Forces?		15. 1	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Blac	ck, White	e, etc.
Ş	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give 17 Year or Dates:		1	I∐Yes 2∏No	Specify:			Specif	y: I	Black
Completed by	15. Decedent's Education	16a	Deced	ient's Usual Occupa	ation		16h	Kind of B	usiness/	Industry
et	(Specify only highest grade completed)		(Give I	kind of work done d OO NOT use retired	furing most of work	ing	100.	7 (11) (1)	401110001	, industry
E	Elementary/Secondary (0-12) College (1-4or 5	+)		ab Driver	,			3016	Emp 1	Loyed
ပိ	12 years 17. Father's Name (First, Middle, Last)		U2	p priver	18. Mother's Name	e (First, Middle			_	LOyeu
Be						Russell	,			
ပ္	John Thorpe	101	B 4 = 181 -	g Address (Street a			014	T	Chaha	Zin Codo)
	19a. Informant's Name/Relationship (Type. Print) Michael Thorpe - Son			Princess						
	<u> </u>			sition (Name of		Date				Town, State
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemeter	y, cren	natory or other place	e) [,	
	4 Donation 5 □Other (Specify)	Ft. Li		oln Cemete						
	21. Signature of Funeral Service Licensee	NA		. Name and Addres					-	
	Mmy, Durett	WY		001 Benni				gton,	DC	
	23a. Par Enter the disease, or complications that caused shock or heart failure. List only one cause on each lir	the death. Do r	not ente	er the mode of dying	g, such as cardiac	or respiratory a	arrest,			Approximate Interval Between
	Immediate Cause (Final disease or condition	ATAR	1	FAIWRE						Onset and Death
	resulting in death)	a consequence of								
	BRAIL	J MI	ET	45 TASE						
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of	of):							
mi	i triat initiated events	JMON,	IA							
Ë	resulting in death) Last Due to (or as	a consequence of	of):							
edical Examiner	d									
		4.00								
3	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		۰۰	Teatanta and insula				23d. Da	ite of de	livery
icia	in the past 12 months?	2 □ Fetal death t time of death		Ectopic pregnancy Other (specify)	y 			M	onth	Day Year
Physician/M	9 Unknown									
Y P	Part II. Other significant conditions contributing to death be	-			en in Part I.	23e. Did	tobacc	o use con	tribute to	o the cause of death?
Completed by	ACUTE CHANGE IN ME	NTAL.	ST.	ATUS		1 🗆	Yes	2 🗌 No	3□ P	robably 4 Unknown
lete						24a. Was	an	24b.	Were a	utopsy findings available
ם						auto	psy		prior to death?	completion of cause of
ပိ	05.11						2 X I	No	1 ☐ Yes	2 No
Be	25. Was case referred to medical examiner?			Othe	26. Place of Deat					
은	1 ☐ Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Inju	ent 2 ER/Ou	itpatien Time of	IL 3 LI DOA	4 LI Nursing Ho	ome 5 ☐ Res 28d. Describe			. ,	ecify)
io	Natural 5 Pending (Month, Da		njury	Work	Yes 2 □No	Zod. Describe	non in	july occur	100	
ical	2 Accident investigation 3 Suicide 6 Could not be 289 Place of Injury	une At homo for	rm etre	eet, factory, office	res 2 🗆 (to	28f Location	Ctront	and Num	hor or P	ural Route Number,
Certification: To	4 Homicide determined building, etc	(Specify)	iii, o.i.c	oot, lactory, onloc		City or To	wn, Sta	ate)	001 01 11	arar route rames,
ŭ	29a. Certifier Certifying Physician: To the best	of my knowledge	death	h occurred at the tin	me date and place	and due to the		a(s) and m	nanner a	s stated
Medical	(Check only 2 Medical Examiner: On the basis of one)	f examination an								
Mec	29b. Signature and title of certifier			29c. License	e number		29d. [Date signe	ed (Mon	th, Day, Year)
	Marie D	~~		NA	VE20	G	۵	1111-	01	2000
	KASHEEL TOASS 1	a a th //t 00 `	(T) (=	Duint)	16032	- /	100	145T	UI	XUU8
	30. Name and address of person who completed cause of d	eath (item 23a) i	Type,		SURRAT	TO DA	AN.	(1	INITI	W 20735
ate	31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	_		SUKKATI	12 10	ソン			00,00
rar	AUG 0 4 2008 Been	A April	white the							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan		artment of	Health and for Death	l Mental H	ygiene Bea. No.	2008	26444
P	hysicia	an	Decedent's Name (First, Middle)		LEEN ALF				2. Date of D Month July	eath	, 20Ŏ8r	3. Time of Death 3:40 P M
	/Medic xamin		4a. Facility Name (If not institution					n, or Location of De			County of Death	
			Kline Hospice				Mt. Ai				rederick	
	neral ector		5. Social Security Number 217-20-6641	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.	last birthday) 7 Yrs.	If Under 1 Ye Months Da		n. 8. Date of B	irth 20, Year	920 Mary	place (State or Foreign Tand
pue	3		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			• • •	1	10d. Inside City Limits
Manyla	f sho led at	lor	Maryland Frede	rick	Mt.	Airy						1 □ Yes 2 No
the l	r 28a- notif	irect	10e. Street and Number				10f. Zip Cod	е		10g. Citi:	zen of What Cou	ntry?
th with	23a o ust be	al D	7000 Kimmel Roa	.d				771			U.S.A.	
5-0036 72 hours after death with the Maryland	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed I	3 2 🛅 No		Was Decedent of If Yes, specify O	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Americ Black, White, Specify: 1,1	etc.
5-0036 72 hours af	ural"; al Exa	d by	3 Widowed 4 □ Divorced	Yearor	Dates:		dent's Usual Oc			16b Ki	nd of Business/In	hite
U 72 ui	n "nat Aedica	plete	15. Decedent (Specify only highes	st grade completed		(Give	kind of work do DO NOT use re	ne during most of w tired)	vorking	I IOD. KI	nd of business/iii	dustry
ZIZI d within giene.	tha the N	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Н	omemake				wn Home	
and A	d othe event	Be	17. Father's Name (First, Middle, William L. Rif					18. Mother's N	lame (First, Midda Tiday	le, Maiden	Surname)	
narylan 2 should be a n and Mental	narke natic	2	19a. Informant's Name/Relationsl			19h Maili	na Address (Str	eet and Number or		her City o	r Town State 7ii	n Code)
and 2 sh	27 Is r r traur		Carolann Hooton		ter			g Bridge.				
or Hea	othe		20a. Method of Disposition	0. 🗆 🗆	I .	Place of Dispo cemetery, cre	osition (Name or matory or other	place)	Date	20c. Lo	cation - City or Te	own, State
Pages ment of	ant: If ury or		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		Mt.		t Cemet				erick, M	-
Baltimore, I permit. Pages 1 and Department of Healt	any Inj once.		21. Signature of Funeral Service	License	es /	RÖ 12	2. Name and Ac BERT E. 01 NORT	dress of Facility DAILEY δ H MARKET	SON, FUI	NERAL EDERI	HOMES,	P.A. 1701
	· G		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the dea n each line.	th. Do not en	ter the mode of	dying, such as card				Approximate Interval Between Onset and Death
	ician		Immediate Cause (Final disease or condition resulting in death)	a	Col	or C	aneer					Onset and Death
	edical miner		resulting in deathy	Due t	o (or as a consec	quence of):						
	\$- \pi_1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury	b. Due t	o (or as a consec	quence of):						
cuted	nd transit	Examiner	triat initiated events	с								
6 ex	physician and the burial-transit		resulting in death) Last	Due t	o (or as a consec	quence of):						
oertificate be executed	physi s the t	edical		d								
BOX (use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregne birth 2 🗆 Fet		∃Ectopic pregna	2004			23d. Date of deliv	ery
o death	ne atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specif)			.	Month	Day Year
hat the	d by the letach	Phy	9 ☐ Unknown Part II. Other significant condition	1		sulting in the u	nderlying cause	given in Part I.	23e. Dio	tobacco u	use contribute to t	the cause of death?
Hecords, P.O.	been signed by the attending p should be detached for use as	ed by	Hepperter			yanıng ili alo a		green and and			□ No 3 □ Pro	
law re	as be	Completed							24a. Wa	topsy	prior to co	opsy findings available ompletion of cause of
	certificate has t irector, page 2 s	Con					<u> </u>		pe 1□ Yes	rformed? 2 No	death? 1 ☐ Yes	21 No
VITAI siclan: T	recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hoepital:	☐Impatient 2☐	ER/Outpatie	nt 3□ DOA	Other:	Death <i>(Check onl)</i> g Home 5 Re		e Mother (Special	HASDICE
	After this certific funeral director,		27. Manner of Death	28a. Da	te of Injury	28b. Time o		njury at Work?	28d. Describ			MIOSPICE
ISIOF Attendin death.	or; After he funera	atio	1 Natural 5 Pendin 2 Accident investig	gation			М	1 ☐ Yes 2 ☐ No				
UIVISION I or Attending after death.	Direct In by t	Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	20E. Fld	ice of injury - At h ilding, etc. <i>(Sp</i> ec	ome, farm, st	reet, factory, off	ice	28f. Location City or 7	(Street an own, State	d Number or Rur)	ral Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death.	Funeral	edical C		Examiner: On the				ne time, date and pla my opinion, death o				
To the within	То th	Med	29b. Signature and title of certifie				29c. Lic	ense number		29d. Da	te signed (Month	, Day, Year)
	^		> How				\Box	5463	9	C	10-8	2008
	9		ao. Name and address of person	who completed ca	ause of death (Ite	m 23a) (Type,	Rint)	Ne Fr	ederic	LKS	ND 21	701
¢.	Sta Regist		31. Date filed (Month, Day, Year)	1 2008 32	. Pogistrar's Sign	ature A	borli					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Willie Mae July Waters 28. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Riverdale Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 1 ☐ M 2 🗓 F 80 South Carolina Director 578-38-7072 Nov. 11, 1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at 1 Yes 2 No must be notified Director Prince George's MD Bowie 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 14997 Health Center Drive 20721 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 N Widowed 4 □ Divorced Year or Dates Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education within 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 'n and Mental Hygiene. 7 Is marked other than "i College (1-4or 5+) Elementary/Secondary (0-12) Division Chief the 2 Years Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 Is marked any injury or other traumatic ev Jake Russell Mary Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Swan Creek Road - Fort Washington, MD 20744 Pamela Terrell - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemt. Aug. 4, 08 | Brentwood, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) terrosclerote Cardiovasalaa Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Encentalopal 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an auter autopsy performed? tate has bage 2 s this certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide ō To the Hospital within 24 hours 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year) AUG 0 4 2008

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

seensbury Rd Hyatts ville MD 20181

		1 - State Registrar	ate of Maryland / Depa <i>Ce</i>	artment of Health ar rtificate of Death	nd Mental Hygie Reg.	ne 2008 26446
Physic		Decedent's Name (First, Middle, Last) James	Abell		2. Date of Death Month August 15	Day 2008 11:10 P M
/Medi Examir		4a. Facility Name (If not institution, give street Genesis Eldercare– He		4b. City, Town, or Location of Dundalk	Death	4c. County of Death Baltimore
Funeral Director	Г	5. Social Security Number 6. Sex 1217–07–1549	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min (Month Day Ye	9. Birthplace (State or Foreign Country) 1915 MAryland
ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
th the Ma or 28a-f s	Funeral Directo	MAryland Baltimore 10e. Street and Number	Dunda	alk 10f. Zip Code	10g.	1 ☐ Yes 2 🛣 No Citizen of What Country?
death wi	ineral [A A	as Decedent Ever in U.S. 13.	21222 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	USA 14. Race - American Indian, Black, White, etc.
5-UU36 72 hours after natural", or ite	þ	1 Never Married 2 Married 1 If	XiYes 2 □ No	1 □Yes 2 No Specify:	derio filcan, etc./	Specify: White
aryiand ZIZI300.35 should be filed within 72 hours after death with the Maryland not Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show umatic event, tre Modical Exeminar must be notified at	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) C	pleted) (Give bllege (1-4or 5+)	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	. Kind of Business/Industry
yland ZI uld be filed wi Mental Hygier arked other th attic event, ID:	Be	8 years 17. Father's Name (First, Middle, Last) Robert Abell	1	Press Operator 18. Mother's Henri	Ma: Name (First, Middle, Maid etta Wilkense	rtin Marietta den Surname) On
DENIUMOYE, MATYIANG ZIZIS-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and the once.	2	19a. Informant's Name/Relationship (Type. P		ng Address (Street and Number	or Rural Route Number, Ci	ty or Town, State, Zip Code)
Ore, IN es 1 and of Health if item 27		Helen Montgomery 20a. Method of Disposition 1 X Burial 2 Cremation 3 Remov	20b. Place of Dispo	Beachwood Road sition (Name of matory or other place)	Date 20c	Location - City or Town, State
Daltimol permit, Pages Department of Important: If if any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeran Service Licensee	Fork Chr	istian Cem. ;	2008	Fork Maryland
D 90 E 2 8		23a. Part 1. Enter the disease, or complication shock, or heart failure. List to yo one cau	or well 7	onnelly Funeral 110 Sollers Poi er the mode of dying, such as ca	nt Road, Dun	dalk MD. 21222
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	A TRIAL Due to (or as a consequence of):		TION	Onset and Death
Examiner	ner	Sequentially list conditions, b.	HYPER TE. Due to (u) as a consequence of).	NSION		
ficate be executed in physician and street burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DEMENT / Due to (or as a consequence of):	A		
ritificate be eyng physician as the burial	ledical	d	-			
To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
v requires that been signed the should be detailed	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
The law recate has bee	Completed				24a. Was an autopsy performed 1 □ Yes 2 •	
vita sician:	o Be	25. Was case referred to medical examiner? 1 Yes 2 1 100 Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other:	Death (Check only one)	2 5 2 4 4 4
ing Phy	II		a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	ing Home 5 ☐ Residence 28d. Describe how in	
al or Attend al or Attend s after death il Director: ,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 □Yes 2 □ No eet, factory, office		t and Number or Rural Route Number, tate)
he Hospit n 24 houn he Funera pletely fille	Medical ((Check only 2 Medical Examiner: (: To the best of my knowledge, deatl on the basis of examination and/or in and manner stated.	h occurred at the time, date and vestigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To t with To t	Σ	29b. Signature and title of certifier	· Tulla Mi	29c. License number	188 29d.	Date signed (Month, Day, Year)
3		Sanadu te	ed cause of death (Item 23a) (Type,	Derket Plan	a Dunc	Palle MD 21222
Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2008	32. Egistrar's Signature	ele .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06130 State of Maryland / Department of Health and Mental Hygiene 2008 26447 Laird Howard Anderson Certificate of Death Rea. No 1. For State Time of Death 2. Date of Death Registrar Month Day August 11, 2008 Decedent's Name (First, Middle,Last) 0950 hrs Physician/ Medical Examiner HOWARD 1c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Somerset Crisfield 448 Charcotte Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or preign WASH DLTON Country) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Foreign **Funeral** Hours Months Days JOVEMBER 1 1965 42 578-88-386 Director 1VM 2 Usual Residence of Decedent 10d. Inside City Limits loc. City, Town or Location 10b County 10a. State Yes 2 No CENTREVILLE s 23a or 28a-f show a notified at once. MD QUEEN PHNES death with the Maryland 10g. Citizen of What Country? Director 10f, Zip Code 10e, Street and Number USA 21617 STRUET 1112 COMMERCE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Specify: WHITF Ves Yes 2 No specify: If Yes. Give Year 4 Divorced Widowed hours after 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done event, the M di al Examiner þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hx Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns njury or other traumatic event, the Medical Ex AUTOMOTIVE SERVICE STATION ATTENDANT 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZORN EUGENIE ANDERSON G. Be DOUGLAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CENTREVILLE, MS 21617 S. COMMERCE STREET /STEP MOTHEST DENAR ANDERSO 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) CLAJYSTAM, STAVOHAH 2 Cremation 3 Burial ARDENT CREMATOR BUNGTIP DOUB Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ARDENT CRIMATION STEN HANDUNG DR JEDD CONVERTE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Fentanyl intoxication /Medical Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27,28a-f,perME, g883 9/16/U8 11 Physician/Medical X UNPENDED attending physician or use as the burial 23d. Date of delivery Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 V No 3 Probably 4 Unknown ò 24b. Were autopsy findings available Completed 24a Was an prior to completion of cause of autopsy death? performed? certificate has b ector, page 2 sh No 1 🗸 No ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: The in 24 hours after death. The Funeral Director: After this certification in the funeral director, pletely filled in by the funeral director, pa 25. Was case referred to medica Residence 6 V Other: Scene Division of Vital Be Other₄ Nursing Home 5 Hospital: 1 DOA examiner? ER/Outpatient Inpatient 2 ٩ 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification: Yes 2 X No Natural Pending FNd 9:50 Fnd 8/11/08 28f. Location (Street,and Number or Rural Route Number, City or Town, State) 448 Charlotte Ave Crisfield, MD Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be found at home 3 Suicide (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** (Check only one) To the 1 within 2-To the F 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier August 12, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

ORIGINAL

2008

08-05853 Clyde J Adams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26448

ac o / taarrio		For State Certificate of Death		eg. No.		(5 "
Physician		gistrar Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day	Year	3. Time of Death 0410 hrs
' Examine	4	Clyde Adams, Jr.	July 31, 2	800		
		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death			County of D	
		Franklin Square Hospital Rosedale			altimore (
-	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Bi	rth (MM/I	DD/YYYY) 9	. Birthplace (State or preign
Funeral Director		Months Days Hours Will.	Feb.	10.		Country) MD
Director		214-62-94//	1			
>-		sual Residence of Decedent Da, State 10b, County 10c. City, Town or Location				10d. Inside City Limits
w any						1 X Yes 2 No
land f sho	<u>ខ្ញុំ]</u>	MD Baltimore Essex 10f. Zip Code		10g. Citi	izen of What	Country?
Mary Mary	မို ြ	Oe. Street and Number	ì	TY	SA]
3a or	<u> </u>	1147 Foxwood Lane 21221 112 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or N			American Indian, Black,
ms 2	e 1	1. Marital Status 1. Marital Status 1. Marital Status 1. Marital Status 2. X Married 1. Never Married 2. X Married 2. X Married 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	- 1	White, e	etc.
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after	اح	3 Wildowed 4 Divolced or Dates: Or Dates: 16a Decedent's Lisual Occupation (Give kind of w	vork done	16b.	Kind of Busin	ness/Industry
hours	eted	during most of working life. DO NO1 use retir	red)			
6 n 72 l san "	je Je	Forklift Operator		F	orms S	Services
303 within ien th	dwo	11 th FORKITT OPERACOL 7. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	Toggio	Mae St	ewar	t	
1215-0036 d be filed within 72 hours afte fental Hygiene. aarked other than "natural", event, the Medical Examiner	Be	Clyde Adams, Sr. Jessie 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 1)	Rural Route N	umber, (City or Town,	State, Zip Code)
D 21 should and Med	ှင		sex, M	D 21	221	
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	-	20s. Method of Disposition 20s. Place of Disposition (Name of cemetery,	Date	200	. Location - C	City or Town, State
or He		1 YBurial 2 Cremation 3 Removal from State crematory or other place)	6 2	008	Raltin	nore, MD
Page Page nent ant:		4 Donation 5 Other Specify: King Memorial Park Aug	, 0, Z	υψο	ратсы	nore; in
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filted within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		4 Donation 5 Other Specify: RING Hellion 121. Signature of Funeral Service Licensee Rernadine V. Scruggs, Per DVR RING Hellion 121. Talk Plant 121. Talk Plant 122. Name and Address of Facility Calvin B. Scruggs 1412 E. Preston St	Funera	l Ho	ome timore	. MD 21213
0 8 9 7 1 1	_	Bernadine V. Scruggs, Per DVR 1412 E. Preston St. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or the death.	or respiratory	arrest, s	hock, or hear	t Approximate Interval
hysician	- 1	failure. List only one cause on each line.				Between Onset and Death
/ledical		Immediate Cause (Final disease a. Head Injuries				
ZXammor		or condition resulting in death) Due to (or as a consequence of):				
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):				
	<u>=</u>	cause. Enter Underlying Cause				
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Medical	X AMENDED #1 as noted per ME, #21 per FI 23a, pt.II, 27,28a-f per me	g883 9	-10-	08 vt	d-Disease
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Box 68 te death certifi the attending	Physician/	Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown		- 1		
BC BC Ithe a	ķ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				bute to the cause of death?
ed by	by F		1 .	Yes 2	2 No 3	Probably 4 V Unknown
ires i	pe l	Bronchopneumonia	24a. W	/as an	24b. V	Vere autopsy findings available
rds requ	let			utopsy erform <u>e</u>		prior to completion of cause of death?
SCO ne lav te has	Completed			es 2		Yes 2 No
R. Tr r: Tr rifica tifica or, pa	ŏ	25. Was case referred to medical 26.Place of Death (Chec				
fita sicial is cer lirecte	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other; 4 Num	sing Home 5		sidence 6	Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death. The range death. All Directors: After this certificate has been signed by the funeral director, page 2 should be detact	Ĕ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?			/ injury occuri	
on C nding th. r: Af	ļ į	1 Natural 5 Pending 7-29-2008 7:47 am			e fall	
Sicology Atter	<u> [</u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locati	on (Stre	eet and Numb	er or Rural Route Number, City
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Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dawithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	💆	20. Cartificat	and due to the	cause(s	s) and manne	r as stated.
the H tin 24 the F	Medical	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ed at the time,			
To To To Com	Se	and manner stated. 29c. License number 29c. License number		2	29d. Date sign	ned (Month, Day, Year)
		O.C.M.E.		1	August 1,	2008
		Tamata Susting May of Joseph (Hom 23a)				
	1	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 2120	1		
		24 Pete filed (Moeth Day Year) 32. Rigistrar's Signature				
	state stra	31. Date filed (Month, Day, Year) AUG 1 6 2008 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Barnes 9:50 AM August 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of maryland mediculcente University Baltimore n/a 8. Date of Birth (Month, Day, Year) 16. 1940 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 250kF 215-40-1924 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Carroll Mt. Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5201 Ridge Road 21771 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: White <u>}</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Carroll County Elementary/Secondary (0-12) College (1-4or 5+) General Hospital LPN 12th 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George C. Thomas Justa Witherspoon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 5201 Ridge Road Mt. Airy, MD 21771 William Barnes, Jr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery Aug. 19, 2006 Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service License 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, alle 1212 W. Old Liberty Road Sykesville, MD 21784 F rt 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death I me ate Cause (Final di mase or condition resulting in death) Respiratory tallure **Physician** /Medical **Examiner** Acute myloid Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-transit Examir and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2 No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Certification: To To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 18954 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Baltmore De bow 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

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erson who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Amend Item 27 per dr., g882,08/18/08dhb	artment of Health and		ene . No. 2008	26451
8		- 9	Decedent's Name (First, Middle, Last)	Timeate of Beating	2. Date of Death		3. Time of Death
^	Physici /Medi		Delores Bailey		Aug ust	7th 2008	2:08 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Bon Secous Hospital	4b. City, Town, or Location of Death	h	4c. County of Death	
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth	9. Birthp	lace (State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			0d. Inside City Limits
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	ith the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Count	try?
	ath wi		1744 W. North Avenue	21217		USA	
	ter de items iner n	Funeral	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Mari	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
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ylar	2 should be and Menta Is marked aumatic ev	To E	Percell Smith		y Macklin		
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altimore,	Pages tment of tant: If it ijury or o		4 □ Donation 5 ☑ Other (Specify) in state	matory or other place)	,	a country of to	m, cato
Bai	permit. Pag Department Important: I any injury o		Ronald Me Director	2. Name and Address of Facility State Anatomy Boar Baltimore, MD 21:		Baltimore	Street
			23a. Part1. Enter the disease, or complications that caused the death. Do not entshock, or heart failure. List only one cause on each line.				Approximate Interval Between
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P.O.	The law requires that the death certi tte has been signed by the attending bage 2 should be detached for use a	Physician/M		Other (specify)		Month [Day Year
σ.	s that t ned by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
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Sior	endin sath. or; Aff he fun	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Di Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director; p	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, S.	t and Number or Rural tate)	Route Number,
	e Hospit 24 hours Funera etely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and manner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To th within To thi compl	Me		29c. License number	29d.	Date signed (Month, D	Pay, Year)
			Marcia Cost, no Physician	must D00522.	40 An	94st 11,	2008
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
1	Sta		29b. Signature and title of certifier Marcia Cort, Mo Bon Science: Hospital 31. Date filed (Month, Day, Year) AUG 1 8 2008 Marcia Cort and Bon Science: Hospital 31. Registrar's Signature AUG 1 8 2008	1000 W. Sailth	one Street	, Balhmon	MD 2/223
	Registra	ar	AUG 1 8 2008 Boson & Spa	was			

Physician /Medical Examiner

the attending physician

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

"natural", or Items 23a or a

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event,

Baltimore, Maryland 21215-0036

the burial-tran

Division or Vital Records, P.O. Box 68760,

Il Examiner

Certification:

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IF FEMALE:

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

29a. Certifier

24a. Was an autopsy performed? res 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

(Month, Day Year)

Hospital: 1 ☐ Inpatient

28a. Date of Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 ☐ Pending investigation

AUG 1 8 2008

29c. License number D 0055127

28c. Injury at Work?

1 TYes

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sallit Drive Stevensville, MD 21666 Margaret 115 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

2 ER/Outpatient 3 DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28a-fper me, g882,08/15/08dhb Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 253P Month avole Coleman July 8000 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Columbia
1 Year | If Under 24 Hrs. Howard If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Days Hours Min. 216-18-0021 Director 84 03 14 24 MD Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 ▼No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13104 Williamfield Drive Funeral 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie 12th grade 6yrs Teacher Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental or other traumatic ည Jeremiah Meekins <u>Harriette Parker</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any Injury or other trau Michelle Coleman-Daughter 13104 Williamfield Drive, Ellicott City, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn 8/1/2008 Marriottsville, Md 21. Si natu e of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gastrointestina! bleed ung Physician /Medical CERTIFICATION COROTED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner HeratuceValar Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine tenatitis be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Right hip dental 1 Yes 2 No 3 Probably 4 Unknown Diabeter mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 Hyperfension perforn certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 2. Accident 07/16/2008 1 ☐ Yes 2 🕱 No after death Director: _Unknown^M Fall while bowling 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Bowling Alley Hospital Ellicott City, MD 24 hours a Evneral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the within 2 29b. Signature and title of certifier 29c. License number July 24 2008 WASCH, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUIF BALTIMORE

State

Registrar

31. Date filed (Month, Day, Year)

AUG 15

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month AUGUST Daniel W. Clav /Medical 4a. Facility Name (If not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Paltimore oital 5. Social Security Number 6 Sex Under 1 Year | If Under 24 Hrs. **Funeral** (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X**□ M 2□ F Months Hours Min. Days 212-16-2089 Yre Director 2-3-1920 87 MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at tyPYes 2 □ No Funeral Director MD N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 20th Street Apt 16 F 11 W. 21218 SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1. Yes 2 No If Aes, Give Year or Dates: Denkey (Bultimore, Maryland 21215-0036 1 □Yes 2 □ No 3 Specify Specify: Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Wates once. Elementary/Secondary (0-12) College (1-4or 5+) Office Building Custodian 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Charles P. Clay Bertha Jennings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Bailey-Niece 5804 Leithwalk Balto, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest 8-20-2008 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List-only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a a consequence of). The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months? If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) ed by the a ☐Yes 2 ☐ No 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIMERAL VASCULAR DISEASE, HYPERIENS 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate ha autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 ☑ Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

AUG 18

2008

ORIGINAL

egistrar's Signature

08-06183 Latre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Latrell E. Clark	4 -	Stata	State	of Maryland /	Departific	cate of L	neamh and Death	MICHICA	111991	Reg.	No.	200	8 254
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Medigai Examina	4 a.	Facility Name (if	not institution, giv	e street and number)		4b	. City, Town, or L		eath	1	Baltimore		
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Funeral	5.	Social Security N	1	Š.,	e (In yrs. last b		Months Days	Hours	Min	9 23		Foreign Country	
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5-0036 led within 72 hours after Hygiene. I other than "natural"; I the Medical Examiner.				only highest grade cor College (1-4 or		during mo	st of working life.	DO NOT u	se retired)				100
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once			ull-Mot	ner	20b. Pla		ition (Name of ce			ate	20c. Location	- City or Tov	vn, State
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Box 6876(ne death certificate tree attending physhold for use as the b	2		nificant conditio			sulting in the	underlying cause	e given in Pa	art I.				e cause of death?
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Division of Vital Records, taler Attending Physician: The law requirers after death. al Director: After this certificate has been sifted in by the funeral director, page 2 should the	icat	2 Acciden	0 - 0 - 11	not be 28e. Place	of Injury - At he	ome, farm, st	reet, factory, offic	e building, e	etc.	28f. Location or Town	(Street and No State)	umber or Rur	al Route Number, City
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Hospi 24 hou Funer tely fi				ysician: To the best on the basis of and manner sta	of my knowled	ge, death oc	curred at the time	, date and p nion, death o	olace, and occurred a	due to the ca t the time, da	use(s) and ma te and place, a	ind due to the	e cause(s)
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				who completed cause nt Medical Exam	or death (Iten	Penn Str	eet, Baltimor	re, MD 21	1201				
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Alana M. Cunningham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	C	ertificate of	Death		Reg.	No.	
Physicia al Exami	an/	1. Decedent's Name (First, Middle, I	Cunningha	m			2. Date of Death	ay Year 008	1431 Hrs
		4a. Facility Name (if not institution, 205 Profesional Place #	- /	41	Gaithersburg			4c. County of Prince G	
Funeral Director		- 0	Sex 7. Age (In yr. M 2 7 44 44	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(1	9. Birthplace (State or Foreign Alabama Country)
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b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ttem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the Medical Examiner must be notified at once	Funeral [205 rosess 11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever in	If Ye	20879 Decedent of Hispa s, specify Cuban, I			14. Race - White,	American Indian, Black, etc.
ours after d atural", or	by	3 Widowed 4 Divorce 15. Decedent's Education (Specific	ced If Yes, Give Year or Dates:	1 16a. Decedent	Yes 2 No s Usual Occupatio st of working life. D	n (Give kind of wo		Specify: 6b. Kind of Bus	Bluck iness/Industry
5-0036 led within 72 h Hygiene. other than "n the Medical E.	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Par	a leg	9/		la	W
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Physician Medical ≟xaminer		failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)		ns of chr				, , , , , , , , , , , , , , , , , , , ,	Between Onset and Death
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c 68760, certificate be ending physic		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of	2 Fet	al death 3 er (Specify)	Ectopic pregnan	су	23d. Date of o	delivery Day Year
P.O. Box 68' that the death certifine ned by the attending detached for use as!	, Physicia	1 Yes 2 No 9 ✔ Unknown	a Dilkilowii			ven in Part I.	23e. Did toba	acco use contril	oute to the cause of death?
ords, P.O. I w requires that the as been signed by the should be detached	eted by						24a. Was an	24b. W	Probably 4 Unknown Vere autopsy findings available
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Division pital or Attendi ours after death.	Certification:	3 Suicide 6 Could determ	not be 28e. Place of Injury - A	At home, farm, stree	, factory, office bu	ilding, etc.	28f. Location (Str or Town, Sta		er or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (one) 2 Medical Exami	sician: To the best of my know ner:On the basis of examinatio and manner stated.	rledge, death occurr on and/or investigation	on, in my opinion,	death occurred at	the time, date an	nd place, and di	ue to the cause(s)
	Σ	29b. Signature and title of certifier	mia-Pac	Olym	29c. License O.C.M			29d. Date signe August 7, 2	d (Month, Day, Year)
		30. Name and address of person w Patricia Aronica-Pollak			111 Penn Stre	eet, Baltimore	e, MD 21201		
St Regist	ate trar	31. Date filed (Month, Day, Year) AUG 18	2008 32. Registrar's Sign		de				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at an once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

Physician /Medical Examiner

and attending physician as ed by the a signed by has (To the recommends after deau..

Within 24 hours after deau..

To the Funeral Director: After this control of the funeral director. this

The law requires that the death certificate be executed

or Attending Physicians

Division or Vital Records, P.O. Box 68760.

Director 2503 Violet Ave - 511 South Completed by Funeral 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clara Dukes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6709 Selkirk Rd, Balt., MD 21239 Theresa Y. Rice/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/20/08 Balt.,MD Mt. Zion Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitHari P. Close F. SVs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hronic ODSTructive pulmorary disease Due to (or as a consequence of): Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Gerzured Border 1 Yes 2 No 3 Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richardson, 340 Parkyeights Ane Backo.

Vear

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

2008

08-06256		Please Type or Print in Black Indelib		
John Franklin D		otato of that yiana, a open and		ygiene 2008 25458
		Registrar 1. Decedent's Name (First, Middle,Last)	e of Death	Reg. No. 2. Date of Death 3. Time of Death
Physicia Medical Exami	S4 0 11/			Month Day Year 1015 hrs
1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	
		Chester River Hospital Center	Chestertown	Kent
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreign
Director		215-18-9012 1X M 2 F 86	Yrs.	9/1/1921 Country Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	_	Maryland Baltimore Essex		1 Yes 2 X No
faryla 18a-f	Director	10e. Street and Number	10g. Citizen of What Country?	
the Na or 3a or 3		201 Oak Avenue	21 221	U. S. A.
Baltimore, MD 21215-0036 gernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Iniportant: If item 7 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	
er deat , or it	Fur	3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2X No specify:	
ırs afte tural" ımine	l by	or Dates:	cedent's Usual Occupation (Give kind of	Specify: White work done 16b. Kind of Business/Industry
72 hou n "nai	eted by	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use ret	ired)
5-0036 led within 7 Hygiene. other than	Comple	12 Ow	ner / Operator	Boat Yard
15-0 filed v Hygi d other	ပို			e (First, Middle, Maiden Surname)
2121 wild be fi Mental I marked	To Be	John Franklin Deckelman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. 19b. 19b. 19b. 19b. 19b. 19b. 19b.	Anna F: Mailing Address (Street and Number or	LCK Rural Route Number, City or Town, State, Zip Code)
MD day		(Son)	28 Nanticoke Road	Essex, Maryland 21221
e, No. 1 and 1 and Health item		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, y or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		1 25 Bullat 2 Cremation 3 Removal non State	s of Faith Cemeter	8/20 y 2008 Overlea, Maryland
Baltil permit. Departm Importa injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bruzdzinski Funera 1407 Old Eastern	al Home DA
		Michael C. Jaffer Sr	1407 Old Eastern	Avenue Essex, Maryland 21221
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) Jue to (or as a consequence of):	Cardiovascular Disease	Death
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Box 68760, e death certificate be ex the attending physician ed for use as the burial	ian/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregn	23d Date of delivery ancy Month Day Year
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P.O.	by P	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ls, F quires en sign				24a. Was an 24b. Were autopsy findings available
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ital ician: s certif rector,	Be	25. Was case referred to medical examiner?	26.Place of Death (Check patient 3 DOA Other Nursi	only one) ng Home 5 Residence 6 Other:
Division of Vital Records, tal or Attending Physician: The law requirers after death. There this certificate has been sited in by the funeral director, page 2 should be a be to be the control of the co	유	27. Manner of Death 28a, Date of Injury 28b. Tir	ne of Injury 28c. Injury at Work?	28d. Describe how injury occurred
on C Inding Ith.	흲	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
r Atte ter des irrecto	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After completely filled in by the funeral	Certification:	4 Homicide determined (Specify)		or Town, State)
Di e Hospital 124 hours s e Funeral etely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	one) 2 Medical Examiner: On the basis of examination and/or invalid and manner stated.		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 16, 2008
TT		my m, m,	U.U.IVI.E.	August 10, 2000
17		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
	tate		f	
Regis	trar	1 11 1 0 711112 LOTA Pr 17.	rown	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day ROBERT HUGH EICKELBERG 12:55 P^M August 13, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OAK CREST VILLAGE Baltimore County Parkville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1X M 2□ F 212**-**03-2893 Feb 24, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore County Maryland 1 ☐ Yes 2 X No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 Walther Blvd, #232 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☑ Yes 2 □ No 143 - 146 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Pension Administrator 5+ Gas & Electric Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hugo Eickelberg <u>Marie</u> Anna Duwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alice E. Mering (Daughter) 7005 Charles Ridge Road, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Transport 1 Description 2 □ Cremation 3 □ Removal from State MD Veterans Cem, Garrison 8/18/08 Owings Mills, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signatu of Fundal Service Ricensee 22 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC D. Lawson Martin 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or njury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans attending p

Physician

/Medical

Examiner

Funeral

Director

urai", or items 23a or 28a-f show I Examiner myst be notified at

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Division or Vital Records, P.O. Box 68760

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Physician/Medical þ Be Completed Medical Certification: To s after dea...al Director: After

1 Yes 2 No 27. Manner of Death

29a. Certifier

5 Pending investigation 1 Natural 2 Accident 3 ☐ Suicide 4 Thomicide

6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Parkville

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MID

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800.

State Registrar

Monias 31. Date filed (Month, Day, Year) AUG 1 8 2008

walther Boulevard 32. Registrar's Signature

within 24 hours at To the Funeral C completely filled

Amend #27, per MD 8882 8/20/08 TT
State of Maryland / Department of Health and Mental Hygiene 0 8

1- State Amend #15, perFH G882 8/18/08 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** Richard 9:30 pM 2008 Fowler Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Road Burnwood Baltimore Year If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-80-1102 Months Days 1**X**M 2□F MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23s or 28s-f show the Mudical Examiner must be notified at Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U54 Burnwood Koad death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item eny Injury or other traumatic event, the Medical Exemples 2002. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Minister Ministr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be Richard Fowler Davis ೭ woretta aword 19a. Informant's Name/Relationship (Type, Print) (W) (E) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road 1710 Burnwood Baltimore, MD. 21239 La Sonya Weeks Fowler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Cemetry 08/25/2008 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name of Address of Fallity Phillip A. Weatherford Funeral SVCS 21. Signature of Funeral Service Licenses rom 2431 E. Oliver Street Baltimore, M.D. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal failure **Physician** /Medical Due to (or as a consequence of): Examiner · Acquired Immunodoficoncy Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner led by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed peed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No hours after death. unerel Director: After this y filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 14027 A somow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas S. Wilson MD 5601 Lock Rowen Blud, Baltimore MD Z1239 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINA

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28 any Injury or other traumatic event, the Medical Eventual Person
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Division of Vital Records, P.O. Box 68760,	al or Attending Physician: The law requires that the death certificate be executed is after death. Il Director: After this certificate has been signed by the attending physician and sidn by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar	State of Mar		rtificate of			eg. No. 200	8 26461
Physicia		1. Decedent's Name (First, Middle, Last) DAVID FRAN		FREUND,	SR.		2. Date of Deat Month AUGUST	Day Year 15, 200	
/Medical Examiner		4a. Facility Name (If not institution, give s		ER		or Location of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 219-74-0567		In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country) RYLAND
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALTI		0c. City, Town or Lo	cation	ESSEX			10d. Inside City Limits 1 □Yes ※No
with the 3a or 28	al Director	10e. Street and Number 1939 SUE CREEK	DRIVE		10f. Zip Code	1221	1	0g. Citizen of What C	,
8 0	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Decedent Eve Armed Forces? 1		Was Decedent of I f Yes, specify Cub I □Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	nerican Indian,
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, tre Pedical Eva once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. I	DO NOT use retire	during most of wor ed)	king	16b. Kind of Business	•
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nould be d Menta narked natic ev	P 0			FREUND		DOROT		(LU'	·
and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Ty) DAVID F. FREUN	•		-	t and Number or Ru REEK DRI		City or Town, State,	Zip Code) 2121
Pages 1 and tof He ant: If Item		20a. Method of Disposition 1 ☐ Burial 2€ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cren				20c. Location - City o	
permit. Pa Departme Important any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	»	METRO C	REMATOR Name and Addre 211 CHE	$\frac{8-18}{2}$ ESACO AV	3-2008 0 7ACH/ROS 7E ROSE	CATONSVII SEDALE FU CDALE, MI	LLE, MD JNERAL HOME D 21237
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Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTATIC Due to (or as a c	LARGE CELLO	- NON-H	OBGKINS	Lympho	MA	FEBRUARY 2006
Examiner and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated, events	Due to (or as a co	onsequence of):					
	Medical Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
S E S	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other <i>(specify)</i>	су		23d. Date of do Month	elivery Day Year
es the igne	^	Part II. Other significant conditions con ASPIRATION PNEU	_	ot resulting in the ur	nderlying cause giv	ven in Part I.		acco use contribute s 2 ☐ No 3 ☐ F	to the cause of death? Probably 47 Unknown
ician: The law r certificate has be ector, page 2 sh	Completed					·····	24a. Was ar autops perform 1 □ Yes 2	y prior to ned? death?	autopsy findings available completion of cause of s 2 \(\sum \) No
Physician: ir this certificated director, praidirector, pr	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatien	t 3 DOA Oth	oor:	th (Check only one	e) nce 6 X Other <i>(Sp</i>	ecify) HOSPICE
eath. or: After th	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Ye		M 1	ryat rk?]Yes 2 □No	28d. Describe ho	w injury occurred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certifi	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (City or Town		
he Hos in 24 hc he Fun pletely	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	cician: To the best of notes: On the basis of ex and manner stated	amination and/or in	n occurred at the to vestigation, in my o	ime, date and place opinion, death occu	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)
vith To t	Σ	29b. Signature and title of contifier	Dn	-	29c. Licens	se number 4395		ed. Date signed (Mor	
5		30. Name and address of person who con DANIEUE DOBERM	npleted cause of death	66/45 N	CHARLES	ST. SUITE			1021204
State	е	31. Date filed (Month, Day, Year)	3 Registrar's	Signature	uli	-1 -4110			

DHMH 17 Rev 1/2001

AUGUST

GUNZELMAN

SABELLE

Legible.

 Birthplace (State or Foreign Country) MD

> 10d. Inside City Limits 1 □Yes 2 XNo

				se Type or Pri State of M						•	•	•
			For State Registrar		,			of Death			g. No. 200	8 261
	Physici	an	1. Decedent's Name (First, Middle Donald William		_				2	. Date of Deatl Month	h Day Yea	3. Time of D
	/Medic	al					Also Oits To			ugust	15 2008	2:20a
9	Examin	er	4a. Facility Name (If not institution 1411 Woodbine V 5. Social Security Number	Vay			Wood!			D (D'.)	4c. County of De	
	Funeral Director		214-46-0836 Usual Residence of Decedent	6. Sex 1 1 1 M 2 □ F 61	ge (In yrs. las	Yrs.		Days Hours	Min.	Date of Birth (Month, Day, ug 21	1946	Birthplace (State or Country) MD
e Maryland a-f show	ctor	10a. State 10b. County MD Carro	11		Town or Loc						10d. Inside City	
	th with the 23a or 28	Funeral Director	10e. Street and Number 1411 Woodbine V	Vay			10f. Zip Co			10	og. Citizen of What G	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 🛣 Marr 3 □ Widowed 4 □ Divorced	ied 12. Was Decedent Armed Forces 1 □Yes &□ If Yes, Give Year or Dates:	?	1	Vas Deceden fYes, specify □Yes 2页	t of Hispanic Or Cuban, Mexica No Specify		ity Yes or No- can, etc.)	14. Race - Ar Black, Wh Specify: Wh		
15-0	"natu	letec	15. Deceden (Specify only higher	t's Education st grade completed)		16a. Deced	lent's Usual C kind of work	Occupation done during more retired)	st of working	,	16b. Kind of Busines	ss/Industry
2121 I within giene. r than '	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		dispa	_		e	emergency	services	
Baltimore, Maryland 21215-0036	uld be file Mental Hy Irked othe Itic event,	To Be C	17. Father's Name (First, Middle, Anthony Joseph						er's Name (nna Po		Aaiden Surname)	
Mary nd 2 shou alth and A	ind 2 shore alth and the 27 is made trauma		19a. Informant's Name/Relations Barbara L. Gaiga		.)		-				, City or Town, State	e, Zip Code)
more,	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				sition (Name natory or othe Memor	of or place)	Dai	ء ا	Sykesville	
Balti	permit. I Departm Importar any Inju		21. Signature of Funeral Service	Licensee				Address of Facil			ral Home 8	Chapel
Ó	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one caus, on each a. Due to (or as	ine. STAFC	c 91	er the mode o	of dying, such a	s cardiac or	respiratory arre	est,	Approximate Interval Betw Onget and D
8760,	cate be executed physician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as								
O. Box 68	or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physi in by the funeral director, page 2 should be detached for use as the t	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal d	léath 3 ⊑	Ectopic preg Other (spec				23d. Date of o	delivery Day Ye
ords, P.	w requires that the de s been signed by the s should be detached f	þ	Part II. Other significant condition	ons contributing to death I	out not result	ing in the un	nderlying caus	se given in Part	l.		pacco use contribute	
II Rec	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed					**			24a. Was an autops perform	y prior t ned death	autopsy findings a to completion of ca ? es 2 \(\sumbolea\) No
Vita	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner?					1	e of Death (Check only op		
of	Phys r this ral dir	<u>۲</u>	1 Yes 2 No 27. Mann of Death	Hospital: 1 ☐ Inpat 28a. Date of Inj	ient 2 E	R/Outpatien					ence 6 Other (S	pecify)
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	1 Natural 5 Pendin investig 3 Suicide 4 Homicide General G	g (Month, Dagation	ay, Year)	Injury	М	. Injury at Work? 1 ☐ Yes 2 ☐ ffice]No		w injury occurred reet and Number or n, State)	Rural Route Numb
_	E Hospital		29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the best Examiner: On the basis and manners	t of my knowl of examination	ledge, death on and/or inv	n occurred at vestigation, ir	the time, date a my opinion, de	and place, and ath occurred	nd due to the c d at the time, d	ause(s) and manner ate and place, and c	r as stated. due to the cause(s)
	Vithi To th	Medical	29b. Signature and title of certific	2			29c. L	icense number	- 1	2	9d. Date signed (Mo	onth Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 18

of death (Item 23a) (Type, Print)

ohn Ghigiarelli	Req	or State istrar	e of Maryland / I		ent of Healt ate of Deatl			_{3. No.} 200	8 2646
Physician Medical Examine	-	Decedent's Name (First, Middle, L John Ghigia		- 4			2. Date of Death Month August 14,	Day Year	3. Time of Death 1448 hrs
200	4a.	Facility Name (if not institution,	give street and number)	5		own, or Location of		4c. County of Death	
Funeral		Baltimore Washington Mocial Security Number 6.		In yrs. last birth		Burnie er 1 Year If Under	24Hrs. 8. Date of Birth	Anne Arundel	hplace (State or
Director	-		XM 2 F	61	Yrs. Months	s Days Hours	Min. 10/10	/1946 Foreig	n untry) PA
any	-	al Residence of Decedent State 10b. County	10	Dc. City, Town	or Location			x	10d. Inside City Limits
daryland 28a-f show	<u>a</u> M	D Anne A	runde1	Glen 1	Burnie				1 Yes 2 X No
th the Maryland 23a or 28a-f she notified at once	2	. Street and Number			10f. Zip		10	g. Citizen of What Cour	ntry?
with th		10 Bay1or Road Marital Status	12. Was Decedent E	ver in U.S.			n? (Specify Yes or No-		can Indian, Black,
or item	21.	X Never Married 2 Marri	1 X Yes 2	No		y Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	
ural",	≧ 3 1	Widowed 4 Divorce Di	ed If Yes, Give Year or Dates: only highest grade compl	eted) 16a. I		X No specify: Occupation (Give k	ind of work done	Specify: Whi	
72 hou n "nat	U 1	Elementary/Secondary (0-12)	College (1-4 or 5+			king life. DO NOT u			
within within giene.	omplete	12 Father's Name (First, Middle, La	ct)		Truck Dr		s Name (First, Middle, M	Trucking	Company
21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medica	۰۰۰ ات		Shigiarelli			Leon		•	
ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiens. It: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	O 19a	. Informant's Name/Relationship	(Type, Print) Fianc	e' l	-	,		ber, City or Town, State	' '
- 2 E E E		Ms Janet Gille Method of Disposition	spie		310 Bay10 of Disposition (Nan		Glen Burnie	e, MD 21061 20c. Location - City or	
Baltimore, permit. Pages I at Department of He, Important: If ite	1	X Burial 2 Cremation			ory or other place) orge Ceme		August 23, 2008	Old Forge	. PA
Baltimo permit. Page Department of Important: injury or oft	21.	Donation 5 Other Spec Signature of Funeral Service Lice		1					remation Svs
	232	. Part I. Enter the disease, or co	Tu)		I ZIId A	Avenue, 5	.w. Gren bi	urnie, mb z	1061 Approximate Interval
Physician /Medical	10	failure. List only one cause on	each line.			or dying, such as ca	rdiac or respiratory arre	st, snock, or near	Between Onset and Death
Examiner		nediate Cause (Final disease condition resulting in death)	a. Temazeram Due to (or as a conseq		ation				
	Sec if a	quentially fist conditions, ny, leading to immediate	b. Due to (or as a conseq	uence of):					
	E cau	ise. Enter Underlying Cause sease or injury that initiated	Due to (or as a conseq	uence of):			<u>-</u> .		ļ
nnd rransit	<u>ا</u> (ش	ents resulting in death) Last	d.						
e be executed burial - transit	낐	UNPENDED			-f, perM	IE, g883	9/16/08 TT		
876(tificate ng phys as the b		Was decedent pregnant in the	23c. If yes, outcome	of pregnancy 2	Fetal death	3 Ectopic	pregnancy	23d. Date of delivery	/ Day Ye ar
Ox 6876 eath certificat eath certificat e attending phy for use as the	の 1	past 12 months? Yes 2 No 9 Unkno	4 Pregnant at tir			cify)			4
D. B. It the de by the ached f	Par	t II. Other significant condition	9OIIKIIOWII	out not resulting	in the underlying	cause given in Par	t I. 23e. Did to	bacco use contribute to	the cause of death?
rds, P.(requires that been signed hould be det	g DA						1 Yes	2 No 3 Prot	oably 4 🗹 Unknown
cords,	ompleted						24a. Was a autops	sy prior to o	topsy findings available completion of cause of
tal Rec	\sim	بر 						med? death? 2 ✓ No 1 Ye	es 2 No
Vital Rechysician: The this certificate I director, page	m	Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/O	promission of the contract of	26.Place of Death (Residence 6 Othe	
J of \ Jing Phy After the funeral	27.	Manner of Death	28a. Date of Injury	28b. 1	Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sion Attendi death. sctor:		Natural 5 Pending Accident Investig				1 Yes 2X			
Division pital or Atten ours after death teral Director: filled in by the	Certification:	Suicide 6 X Could n Homicide determine	ot be	y-Athome, fa und at		, office building, etc	28f. Location (S or Town, St GLen Bu	ate) 310 Bay1 ate) MD	or Rd.
	 29a		ician: To the best of my ler: On the basis of exami						
F % F %	29b	. Signature and title of certifier	LIND		290	. License number		29d. Date signed (Mo	
1 2	-	None		th /ltcm 00-1		O.C.M.E.		August 15, 2008	
DX PERD.		Name and address of person who Donna M. Vincenti, MD	Assistant Medica	I Examiner	111 Penn :	Street, Baltimo	ore, MD 21201		
Stat Registra	te ^{31.} ar	Date filed (Month, Pay Year)	82. Registrar's	Signature	sarks.				
DHMH 17 Rev 1/200)1			OR	IGINAL				

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036

Phys /Me Exar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. 31. Date filed (Month, Day, Year) State AUG 1 8 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of M	aryland	/ Depa	artment of I	Health and M	lental Hygie	ene	
	1 - State Registrar			Cei	rtificate of	Death	Reg	No. 2008	26465
n	Decedent's Name (First, Middle, I	Last)					Date of Death Month	Day Year	3. Time of Death
al	Walter Michae 4a. Facility Name (If not institution,				Ab City Town	or Location of Death	August	12 2008 4c. County of Dea	2:25 PM
r	Shady Grove Adve					ville		,	
		Sex 7. Âç	je (In yrs. la:		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	Montgome (ear) 9. Bii	rthplace (State or Foreign Jountry)
	471-12-0332	129 M 2□F	88_	Yrs.	Months Days			, 1920 Mir	
	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
į.	Maryland Manta			D.	-1111 -	ŕ			1X Yes 2 □ No
Diecio	Maryland Monts 10e. Street and Number	comery			10f. Zip Code		10g	. Citizen of What C	ountry?
<u></u>	1107 Edmonston I	rive			20	851	Ur	nited_Sta	tes
runeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
2	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Van Giva			1 □Yes 2⊠No	Specify:		Specify:	
	15. Decedent's		MMTT	16a. Dece	dent's Usual Occu	pation	16	b. Kind of Business	ite s/Industry
2	(Specify only highest of Elementary/Secondary (0-12)		5+1	(Give		during most of worki	ing		
completed	12			Contr	actor		Co	oncrete Co	onstruction
	17. Father's Name (First, Middle, La	st)				18. Mother's Name	e (First, Middle, Ma	iden Surname)	
2	Emil Golnick						ot Availa		
	19a. Informant's Name/Relationship					and Number or Rura			. ,
-	Dorothy Mae Golr 20a. Method of Disposition	ick/ wife	20h Pla	1107	Edmonsto			e. Marylar	nd 20851-161
	1 ☐ Burial 2 🖾 Cremation 3				sition (Name of matory or other pla	2000		c. Location - Ony or	Town, State
	4 □ Donation 5 □ Other (Spe 21. Signature → Funeral Service Lie		Montg		rematorium		1 1 1	ethesda,	Maryland
	De 16 0 65	M01	522			ss of Facility Cumphrey F			
	23a. Part 1. Enter the disease, or co	mplications that cause	the death.						Maryland 2085 Approximate
	shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ne.	A . 10					Interval Between Onset and Death
	disease or condition resulting in death)	a. Due to (or as	a conseque	nce of):					
		. 50	200	V (Proof				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a onseque	nce of):	t day				
	Cause (Disease or injury that initiated events	c C	and	ae	avres	4			
	resulting in death) Last	Due to (or as	a conseque	nce of):					
2		d	Ven	of the	Na_				
	IF FEMALE:	00- 16	,						!
I II yaloldi iyild	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	leath 3[Ectopic pregnanc	су		23d. Date of de Month	elivery Day Year
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of dea	ath 5L	Other (specify) _			, mornar	Day Tou.
	Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
							1 ☐ Yes	2 X No 3 ☐ F	Probably 4 Unknown
							24a. Was an	24h Ware a	utopsy findings available
Compress					 -		autopsy	prior to	completion of cause of
5	25. Was case referred to medical					00 51 - (5 4	1 □ Yes 2	No 1 □Ye	s 2□No
П	examiner?	Hospital: 12 Inpati	ent 2∏ F	R/Outnatier	nt 3 DOA Oth	or'	n (Check only one)	ce 6 ☐ Other (Spi	
	27. Manner of Death	28a. Date of Inju	iry 2	8b. Time of			28d. Describe how		есіту)
	1 Natural 5 □ Pending 2 □ ccident investigat	(<i>Month, Da</i>	ly, rear)	Injury		k? lYes 2 □No			
	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of inj	ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stree City or Town,		Rural Route Number,
								,	
	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of my knowl	edge, deat	h occurred at the t	ime, date and place,	and due to the cau	ise(s) and manner a	as stated.
	N	and manner st	ated.						
	29b. Signature and title of certifier	NXV	\		29c. Licens		290	I. Date signed (Mon	th, Day, Year)
	MA	10/0	ر 			0 5757	7	011	_
	30. Name and address of person wh		,	, , , , ,	,				
	Dr. Ahmed Heshmet	- 10110 Ma	7 7 -	7			0/	10EA	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, g, perffl, G882, 8/18/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Charls Horney August 17, 2008 8:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3635 Glenwood Rd. Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours 1 □ M 2 🖫 F Director 227 40 2346 78 March 4,1930 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Medical Example or must be 12 tified at Director 1 □Yes 2 X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hours after death with 3635 Glenwood Rd. 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status "natural", or if 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ģ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'nn any injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) 12 Butcher Meat Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Carter Elizabeth Caudill ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Frye Sr. 3635 Glenwood Rd. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 8/21/2008 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENFARCTION MYOCARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Year Day 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Presmonary OBSTRUCTIVE DISSASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2. ■No certificate 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation hours after death.
uneral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philadelphia Rd 31. Date filed (Month, Day, Year) State **AUG 18** 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 15, 2008 5:15 John Ward Hammond, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1802 Redwood Avenue Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/25/1959 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Age (In yrs. last birthday) 15€M 2□ F 49 Yrs. 213-76-4631 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X7 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 Redwood Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2**XX**io 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2\tag{\text{No}} Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Truck Driver Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hammond, Sr. Bernice Hedrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Hammond (Mother) 1802 Redwood Avenue, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 8/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIRRHOSIS disease or condition resulting in death) 2006 Due to (or as a consequence of): ALCOHOLISM Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to for as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES UNICON TROULED 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown MYPERTENSON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vas 2 No HEPATITIS 2 □No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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items 23a

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"natural",

12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "no

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce.

Physician

/Medical

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After this funeral

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Saltimore, Maryland 21215-0036

Director

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Completed

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Examiner

Physician/Medical

Completed by

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Medical Certification: To

29a, Certifier

traumatic event, the Medical Examiner must be notified at

Division of Vital Records.

1 hours after death. filled in by To the Hospital within 24 hours a To the Funeral C completely filled State

Registrar DHMH 17 Rev 1/2001 SPERHNG, M.D

and manner stated.

D28987

29d. Date signed (Month, Day, Year)

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

8-15-08

5601 LOCH RAVEN BLUD

			1 _ State	epartment of Health and Mental Hygiene Certificate of Death Reg. No. 2008 25468
	_		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici: /Medic		Sally W. Heeter	Aug. 14 2008 11:00A.
	Examin		4a. Facility Name (If not institution, give street and number) 3711 Collier Road	4b. City, Town, or Location of Death Randallstown 4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 149-26-9989 6. Sex 1 □ M 2 H 7. Age (In yrs. last birth	Months Days Hours Min Month Day Year) Country
	and		Usual Residence of Decedent 10a. State	or Location 10d. Inside City Limits
	Maryla -f sho	tor		llstown 1 □ Yes 2 No
	a or 28a	Funeral Director	10e. Street and Number 3711 Collier Road	10f. Zip Code 10g. Citizen of What Country? United States
920	be filed within 72 hours after death with the Maryland rital Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examirar must be notified at	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes YNo Specify: 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	ithin 72 ho ne. han "natu Mudeal	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) (College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of working file. DO NOT use retired) 16b. Kind of Business/Industry
73	should be filed within and Mental Hygiene. marked other than " umatic event, It. Me	Be	12th 17. Father's Name (First, Middle, Last) Harry Walker	Book keeper United Optical 18. Mother's Name (First, Middle, Maiden Surname) Marian Jorgenson
ıry	d 2 should th and Mer 7 Is marke traumatic	으	-	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	od 2 lith a 27 is r tra		Harold Heeter Husband 37	11 Collier Road Randallstown, MD 21133
Baltimore,	ages ent of nt: If it		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	isposition (Name of crematory of other place) Carroll Crematory Aug. 18, 2008 Winfield, MD
Bal	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 21784
			23a Part 1. Inter the disease or complications that caused the death. Do no shock or heart failure. List only one cause on each line.	I Interval Between
and a	Physician /Medical		Infimediate Cause (Final disease or condition taediting in death) a. Due to (or as a consequence of	NOTH OF LYNG
	Examiner	ir	Sequentially list conditions, b.	
	cuted id ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
90,	icate be executed physician and the burial-transit	I Exa	resulting in death) Last Due to (or as a consequence of	
		dical	d	
O. Box (The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 23d. Date of delivery 5 ☐ Other (specify) Month Day Year
s, P.	res that t signed by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ord	w require been si should b	eted		1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	lan: The law rtificate has t tor, page 2 s	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1 □ Yes 2 □ No
Σ.	<u>9</u> 9	Be	25. Was case referred to medical examiner? 1 Yes 2 1 Nespital: 1 Inpatient 2 FR/Outr	26. Place of Death (Check only one)
		n: To	27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at 28d. Describe how injury occurred
Division	Attending ir death. ector: After by the funer	catic	2 Accident investigation	M 1 □Yes 2 □No
Divi	= 5 th of	Certification:	4 Homicide determined 28e. Place of Injury - At home, farn building, etc. (Specify)	a, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Vith Com	M	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) August 18, 2008
1	, Y		30. Name and address of person who completed cause of death (Item 23a) (T	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2008	all and a second

Registrar DHMH 17 Rev 1/2001

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			For State Registrar	State of Marylar		artment of He rtificate of D			ene2008	26469
ı	Physici		Decedent's Name (First, Middle, Last George Cam	neron Hayne	s			2. Date of Death Month	15 2008	3. Time of Death 3. P. M.
	/Medio		4a. Fecility Name (If not institution, given Baltimore Washing	street and number)		4b. City, Town, or L			4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. S 215-16-6100				If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 07-17-19	(ear) 9. Birtl (23 Mar	hplace (State or Foreign untry) y Land
	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		ty. Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 1 No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 1401 Saunders Wa			10f. Zip Code 2106	1	10g	U.S.A.	untry?
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. I hatural', or items 23e or 28e-f show a other than "natural", or items 23e or 28e-f show avent, the Medical Exercities in set the netities at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 24 No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	panic Origin? (Spe , Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
21215-0036	ithin 72 hou 18. 18n "natura 1 Musical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occupati kind of work done dui DO NOT use retired)	ring most of workii	ng	b. Kind of Business/	Industry
Q	filed Hygid other	Be	17. Father's Name (First, Middle, Last)		Mecha	nic/Elect	8. Mother's Name	(First, Middle, Ma	•	Store
Maryland	nd 2 should lith and Mer 27 is marku r traumatic	5	James Haynes 19a. Informant's Name/Relationship (Eugene J.	Type, Print) Step-Son Sessa		ng Address (Street an Darkholl		l Route Number, C		_
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If item 27 is marked any injury or other traumatic av <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place) s Cemetery	A11911	st 21,	oc. Location - City or Baltimore	
Balt	permit. Departrimports any inj		21 Stignature of Funeral Service Licer	M00918	22	2. Name and Address 2nd Avent	of Facility Singue, S.W.			remationSvs. 1061
5, ct	Physicien end physicien end physicien end physicien end the prival-transit the prival-transit physicien by the prival-transit physicien	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Characteristics on each line. a. Characteristics on each line. Due to (or as a consect to cons	quence of):		^	er respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certifi a attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn Live birth 2 Fet. 4 Pregnant at time of 6	al death 3 death 5	Ectopic pregnancy			23d. Date of dei Month	Day Year
Records,	aw requires is been sigr 2 should be	Completed by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause given	in Part I.	23e. Did tobal 1 Yes 24a. Was an autopsy	24b. Were au	othe cause of death? obably 4 Unknown Itopsy findings available completion of cause of
of Vital B	yaician: Th s certificete director, pag	To Be Con	25. Was case referred to medical examiner? 1 □ Yes >>> No	Hospitat: 15 Inpatient 2] ER/Outpatier	Other		(Check only one)	death? 1 Yes	2□ No
Division of	ding P. After fune	Certification: T	27. Manner of Death 1 Naturat 5 Pending investigation 3 Suicide 6 Could not b determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28c. Injury a Work? M 1 ☐ Ye	at 2 es 2 □ No	28d. Describe how	injury occurred	
	Hospits 4 hours Funeral ely title	edical C	29a. Certifier (Check only one) 1 Certifying Ph	rysician: To the best of my kn niner: On the basis of examin and manner stated.	wledge davi ation and/or in	h accurred at the time vestigation, in my opir	data and place a nion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated to the cause(s)
)	To the I within 2 To the Complet	Me	29b. Signature and title of certifier	γ/\b.		29c. License r	number 977	29d	Date signed (Month	h, Day, Year) 2008
	6		more Pregarin.	completed cause of death (Ite	1 Pu	we, alm	Burn	nè. m	10 20b	/,
8	Sta Registi		31. Date fited (Month, Day, Year) AUG 1 8 2008	32. Registrar's Sign	Spark.	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For Amend Item 24 Registrar	la per verb.,	1882,08/18	Pari nent of H	ieaith and iv Death	rentar mygi Re	g. No. 2008	26470	
Physic	cian	1. Decedent's Name (First, Middle, La	,				Date of Death Month	Day Year	3. Time of Death	
/Med		Herbert L. Harr			1		July 30	T	9:55 AM M	
Exam	iner	4a. Facility Name (If not institution, given	,	0		Location of Death		4c. County of Deat		
.		Montgomery Villa 5. Social Security Number 6.5		(In yrs. last birth		ery VIlla	.ge 8. Date of Birth	Montgon	nery thplace (State or Foreign	
Funera Directo		214-60-0738	X M 2□ F	57 Y	Months Days	Hours Min.	(Month, Day, Apr 25,	Year) Co	yland	
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	r Location				10d. Inside City Limits	
Mary I-f sh	tor	MD Montgom	ery	Montg	omery Villa	ge			1 □ Yes 2√∑ No	
h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
th wit	ra	19301 Watkins Mi	ll Road			20886		USA		
r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of His If Yes, specify Cuba 	ispanic Origin? (Spent) In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
Ind 21215-0036 be filed within 72 hours after death with the Maryland tital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mardial Every or 18 and 18 an	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ∐Yes 2 🛣N If Yes, Give Year or Dates:	0	1 □Yes 2 No	Specify:		Specify: wh		
5-0 72 hc 'natur	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)		ecedent's Usual Occupa		ing 1	6b. Kind of Business/	Industry	
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	To Be	17. Father's Name (First, Wilduie, Last	,		unk	16. Mother's Name	; (First, Wilddie, W	alderi Surname)	unk	
re, Marylar s 1 and 2 should be if Health and Menta ttem 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship	Type. Print)	19b. I	Mailing Address (Street a	and Number or Rura	al Route Number,	City or Town, State, 2	Zip Code)	
		Michelle Harris/	laughter	521	S. Frederic	ck Avenue	#307 Ga	ithersburg	, MD_20877	
0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D	isposition (Name of crematory or other place	e) [20c. Location - City or	Town, State	
Limor Pages tment of tant: If it		4 □ Donation 5 ☑ Other (Special	in state							
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other		21. Signal to 1 Funeral Survice Lice	Wade, Dire	ctor	22. Name and Addres State Anat Baltimore	ss of Facility Lomy Board	d 655 W.	Baltimore	Street	
		23a. Part 1. Enter the disease, or com	plications that caused	the death. Do no				est,	Approximate Interval Between	
Physician	1 1	shock, or heart failure. List only Immediate cause (Final disease or condition			votic C	india	19312/0	" Milco	Onset and Death	
/Medica		resulting in death)		consequence of	:			4 0.1		
Examine		Sequentially list conditions	p. 147		en sich					
ted	Examiner	Se ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	7.	consequence of	well	tue				
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68760, rificate be executed g physician and as the burial-transit			(Q) (rivba	qvesi-	2				
	Medical	IE EEMALE.								
death cer e attendin	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		3 ☐ Ectopic pregnance	v		23d. Date of de		
. 0 00	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify)			Month	Day Year	
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of Vita Physician: rthis certific ral director, I	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Outp	atient 3 DOA Othe	ar: N	,	nce 6 ☐ Other (Spe	ecify)	
ON O		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tir (<i>Year</i>) Inj	ne of 28c. Injury	y at	28d. Describe ho			
VISION Attending of death. ector: After by the funer	catic	2 Accident investigatio	n		·	Yes 2 □ No				
Division of Vital I or Attending Physician: 1 after death. Director: After this certificat d in by the funeral director, p	Certification:	4 Homicide determined		ry - At home, farn . <i>(Specify)</i>	n, street, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,	
pita purs ours eral		29a. Certifier 1 Certifying P	nysician: To the best of	of my knowledge,	death occurred at the tir	me, date and place,	and due to the ca	ause(s) and manner a	s stated.	
the Hos nin 24 hc the Fun tpletely	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and	or investigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	to the cause(s)	
To the within 2 To the comple	Σ	29b. Signature and title of certifier	4		29c. License			d. Date signed (Mont		
		Inu Gar	\У		Da	1105-80	D J	Jusent	4 5008	
		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	Vpe, Print) Oni Drive	Gen	wante	un Do	020276	
s	tate	31. Date filed (Month, Day, Year)	1 1 3 "	r's Signature	hast.		41110		- 514	
Regis	trar	31. Date filed (Month, Day, Year) AUG I 8 2008 32. Egistrar's Signature								

08-05721 Paul Lynn Hargrove

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 26471

		- For State	(Certificate	of Death		, 0	Reg. No.			
Physicia	n/	1. Decedent's Name (First, Middle,L					2. Date of De Month	Day	Year	3. Time of Death 2319 hrs	
ledical Examir		Paul Lynn Har			Ab Oth To	n or Leastion	July 25,		County of Dea		
3		4a. Facility Name (if not institution, q Laurel Regional Hospital			Laurel	n, or Location	or Death		ince Georg		
Funeral			Sex 7. Age (In y	rs. last birthday	() If Under Months			Birth(MM/DI	Fore	irthplace (State or	
Director		579-86-7523	XX M 2 F	48	Yrs. Months	Days Hours	April	11,1		country) D.C.	
2		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ncation			-		10d. Inside City Limits	
_ 0M ar				Laurel						1 X Yes 2 No	
rylanc	양	10e. Street and Number	Georges	Laurer	10f. Zip C	ode		10g. Citize	10g. Citizen of What Country?		
MD 21215-0036 d 2 should be filled within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho unmaric event, the Medical Examiner must be notified at once	Director	48- Alma Avenue				20723		U.S	U.S.A		
with 1 ns 23s		11. Marital Status	12. Was Decedent Ever	in U.S. 13			igin? (Specify Yes or I			erican Indian, Black,	
death or iter	Funeral	1 Never Married 2 XX Marri	1 X Yes 2 N	No					Specify: B1		
s after raf",	à		ced If Yes, Give Year or Dates:	1 16n Door		No specify	kind of work done		nd of Busines		
"natu	te d	 Decedent's Education (Specify Elementary/Secondary (0-12) 	College (1-4 or 5+)		ng most of worki			TOD. KI	na or basines	ormodou y	
36 hin 73 e. than	Completed	Elomontary (o 12)	1(±)	Shi	ft Supe	rvisor		La	urel C	ity Govt.	
5-00 ed will fygier other		17. Father's Name (First, Middle, La	ast)		-	18.Mothe	er's Name (First, Middle		Surname)		
121 be fill ental F urked vent, i	a	John Hargrove			Carrie Taggart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,					7.011	
D 2 should and Mis ma	٢	19a. Informant's Name/Relationship Starlette Hargre					Laurel, Ma				
	-	20a. Method of Disposition			sposition (Name		Date Date	20c. L	ocation - City	or Town, State	
ges l tt of H	Ш	1 XXBurial 2 Cremation		•	or other place)			, T	1		
Baltimore, permit, Pages I an Department of Hea Important: If ite	-	4 Donation 5 Other Spec 21. Signature of Funeral Service Li		Harmony	Mem. U 22. Name and A	emetery ddress of Facili	Aug.4,200 ity Marshall	s Fun	eral H	ome, Inc.	
Ban Depu		JATA.	arshall	1	4217 - 9t	n Stree	t, N.W. Wa	shing	ton, D	,	
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		or condition resulting in death)	Due to (or as a consequer	nce of):						2	
	ě	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):	Last Contrac						
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ecuted and transit		events resulting in death) Last	d.	100 017.							
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Box e death of the atten	Physician	1 Yes 2 No 9 Unkn		5	_ Other (Speci						
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of Vital Records, ng Physician: The law requir Helaw toguir this certificate has been sineral director, page 2 should ineral director, page 2 should	Completed						1 🗸 Y				
tal Rec cian: The certificate ector, page	Be (25. Was case referred to medical examiner?	Hospital:			Othor	th (Check only one)		0 0	Ab	
f Vi Physi er this	ပ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outp		Bc. Injury at Wo	Nursing Home 5 ork? 28d. Descr	Reside	ury occurred	ther:	
ion of tending Pheath.	ion:	1 X Natural 5 Pendir	(Month, Day, Year)		,,	1 Yes 2					
Division tal or Attendi rs after death.	ficat		igation not be 28e. Place of Injury	- At home, farm	, street, factory,	office building,			nd Number o	Rural Route Number, City	
Divis ospital or / hours after ineral Dire	Certification:	3 Suicide 6 Could 4 Homicide determ					or low	n, State)		9	
= 4 g = 1		Tomoun only	ysician: To the best of my kno	owledge, death	occurred at the	time, date and	place, and due to the	cause(s) an	d manner as	stated.	
To the within To the comple	Medical		niner: On the basis of examina and manner stated.	ition and/or inve		License numb				(Month, Day, Year)	
La pendy	2	29b. Signature and title of certifier	41		290	O.C.M.E.	OCME		/ 29, 2008	,, Say, 1001/	
		Theoder, M	King of The	/(Item 22a)					, ====		
2		 Name and address of person we Theodore M. King, Jr., 			er 111 Pe	nn Street, E	Baltimore, MD 21	201			
	tate	31. Date filed (Month, Day Year)	2008 32 Registrar's S	ignature	Coast 1						
Regis		MUCLU		400	CALL THE PARTY OF						

State Registrar

GROFFRE 31. Date filed (Month, Day, Year)

AUG 15

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEINFELI

29c. License number

D66 335

SOUTH GREENE ST

29d. Date signed (Month, Day, Year)

BALTIMORE

21201

JUNE 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Items 23a, Pt,I,II,25,27a-fficate of Dealth, 08/15/08dhb Registrar Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Month 1937 PM 2008 07 /Medical 4a. Facility Name (If not institution, give street and BSN SECOURS 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMOLE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Year | If Under 24 Hrs 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 □ F unk 217-54-7161 56 Director Aug 7, 1951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director MD 1 √ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3602 Duvall Street 21225 USA Funeral unk 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry un

unk

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2000 W. Baltimore Street Baltimore, MD

unk

21223

24b. Were autopsy findings available prior to completion of cause of death?

2 No

23e. Did tobacco use contribute to the cause of death?

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28f

autopsy perform

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes

28d. Describe how injury occurred Subject tripped

Location (Street and Number or Rural Route Number City or Town, State) 2000 Was Baltim

Street, Baltimore, MD Baltimore

29d. Date signed (Month, Day, Year)

and fell in bathroom

hours

20c. Location - City or Town, State

filed within 72 hours after death with the Maryland Items 23a or 28a-f show Examiner must be notified at Baltimore, Maryland 21215-0036 'natural", or and Mental Hygi Be Pages 1 and 2 should be nent of Health and Mental other traumatic 2 permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other

Elementary/Secondary (0-12)

20a. Method of Disposition

9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

onel

4 Homicide

(Check only

Anoxic Encephalopathy

5 Pending investigation

6 ☐ Could not be

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State

Bon Secours Hospital

unk

2

2

ln di re

Ca Ch th

College (1-4or 5+)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient Date of Injury

Quite Day Year)

<u>Hospital</u>

2000

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

07708/2008

9☐Unknown

unk

Physician /Medical Examiner

law requires that the death certificate be executed

Box 68760

o.

Division or Vital Records,

Physician:

Hospital or Attending

3a,

ρ the has after death Director:

in by within 24 hours a To the Funeral L

Examine Physician/Medical Completed by Be Certification: To Medical

Signature Tuneral Ticet	wase Director	State Anatomy Board 6 Baltimore, MD 21201	555 W. Baltimore	Street
Ja. Part Enter the disease, or of shock or heart failure. List of mediate C u. se (Final sease or condition sulting in death)	a. CAFOI 06ENIC	not enter the mode of dying, such as cardiac or respect to the Refractory		Approximate Interval Between Onset and Death
equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. Due to (or as a consequence of Presumed Pulmo Due to (or as a consequence of Immobilization Due to (or as a consequence of Orthopedic Su	onary Embolus on: con certification Approve	D BY MEDICAL EXAMINER	12 hours
FEMALE: ib. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	lelivery Day Year

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes

2 No

2 ER/Outpatient 3 DOA

Found: 10:15 p.

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 A. ISAACS -August /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of mary and marked Contre Baltimora Iniversi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Feb. 14, 1930 Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛣 F 78 217-26-5838 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 21 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8024 Hadfield Court 21122 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married 21215-0036 1 □ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Company Secretary Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Griffith George Albert Wassell Esther ဂ္ permit. Pages 1 and 2 shoul Department of Health and Mr Important: If Item 27 is mark any injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8024 Hatfield Court Pasadena, MD Ms. Kathy Isaacs daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility nature of Funeral Service Licensee M00918 Singleton Funeral & Cremation Svs. Danwater Glen Burnie, MD 21061 2nd Avenue, S.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Pseudonaonas 08/12/08-/Medical Due to (or as a consequence of): **Examiner** US. Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director; After this certificate has been signed by the attending physician and yi illied in by the funeral director, page 2 should be detached for use as the burial-transit yi illied in by the funeral director, page 2 should be detached for use as the burial-transit. Septic Sh Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2,000 24a. Was an autopsy performed Division of Vital 2 No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S SS I CHE 27 Green St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Jones Jennifer Jr. Harold 80 12 2008 07:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's County Hospital Leonardtown
If Under 1 Year | If Under 24 Hrs. | Marys Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) (State or Foreign **Funeral X**□M 2□F Hours Days 578-22-3905 86 Director 03 03 DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director Annapolis 1 ☐ Yes 2 X No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 U.S.A. 1400 Chesapeake Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 X Divorced "natural" Be Completed the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coldwell Banker al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Realty Realtor 12th grade **6years** 1 and 2 should be filed thealth and Mental Hygis em 27 is marked other ther traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harold J. Jennifer Sr. Mary Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 6149 Sinbad Place, Columbia, Md 21045 <u> Clinton Jennifer-Son</u> other permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 8/15/08 Baltimore, Md Metro. 21. Signature of Juneral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiac Physician disease or condition resulting in death) MINUTE /Medical Due to (or as a consequence of): Examiner leiminas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably iknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy page 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence Medical Certification: To 1 Yes 2 1 Inpatient 2[R/Outpatient 3 DOA 6 ☐Other (Specify) Date of Injury (Month, Day Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

Director: After i 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funeral ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital

(Check only

30. Name and a

31. Date filed Mor

29b. Signature and title of certifier

RAPH

, Day, Year, 1 8 2008

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 1/2001 dreșs of person who completed cause of death (Item 23a) (Type, Print)

KOUISTON

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month August 12, Day 2008 Year **Physician** 8:31 A. M Nick A. Komons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery ROCKVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Feb. 3, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**½** M 2□ F 233-36-2280 79 Greece Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10618 Great Arbor Drive 20854 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1951-53 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)
5+ Historian Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill trent of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Be Alexander Nick Komons Angeline Rodini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Cristine Komons / Wife 10618 Great Arbor Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State August 2008 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 16, permit. Page Department of Important: If any Injury or once. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 21. Signature of Funeral Service Licen R& Name and Address of Familia Puneral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure unknown /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š this certificate has been si at director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an autopsy performed 1 X Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Monatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of al or Attending P safter death. I Director: After t d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12X

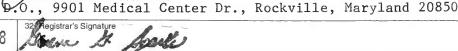
State Registrar

31. Date filed (Month, Day, Year) AUG 18 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certification

Meenakshi Andrew,



D. O.

29c. License number

H66189

29d. Date signed (Month, Day, Year)

August 12, 2008

	For State	Otato or i	vion y ion ion	Certifica	nt of Health a te of Death		Re	eg. No.	3. Time of Death
ysician/ 1	. Decedent's Name (First,	Middle,Last)		1 . 141			2. Date of Deal Month August 12	Day Year	1520 hrs
xaminer	Michae	DW	aune	1111€	4b. City. Town	or Location of De	ath August 12	4c. County of D	Death
4	ia. Facility Name (if not in: 4100 block Barrir		et and number)		Baltimore				The second second
neral	5. Social Security Number		7. Age	(In yrs. last birth	day) If Under 1 \ Months I		Min	i	Birthplace (State or Fore Country)
	218-04-929	0 1XM	2F	28	Yrs.	Jays House	07/2	3/1980	MD.
	Usual Residence of Deced	dent		10c. City, Town	or Location				10d. Inside City Lim
æ		ounty	ļ		Baltimo	re			1 X Yes 2
ment of Health and Mental Hygiene. taut: If item 27 is marked other than "natural", or items 23a or 28a-f show taut: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number				10f. Zip Coo	le		10g. Citizen of What	Country?
a or 28a-f sh tified at once Director	912. Horak	cer Coi	irt		211	225		U5/	American Indian, Black,
ns 23a be not	11. Marital Status		. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify C	f Hispanic Origin? Jban, Mexican, Pi	(Specify Yes or Nuerto Rican, etc.)	White,	etc. Bi-racial
or items 23 must be no Funeral	1 Never Married 2	Married 1 Divorced If Y	Yes 2	X No	1 Yes 2	No specify:		Specify: 1	Black
by Brita	3 Widowed 4 15. Decedent's Education			npleted) 16a.	Decedent's Usual Occ during most of working	unation (Give kin	d of work done	16b. Kind of Busi	ness/Industry
"nati Exai	Elementary/Secondary		College (1-4 or					11.00	.) d
lygiene. other than "natu he Medical Exan Completed	10 11				unempl	1/18 Mother's	Name (First, Middle	Uncm , Maiden Surname)	ployed
Hygie d other the N	17. Father's Name (First,	Middle, Last) U	NK		b. Mailing Address	Cath	erine N	March	
a Mental Hygi s marked othoric event, the To Be Co	19a. Informant's Name/F	elationship (Type	e, Print) (brot	hec) 19	b. Mailing Address	Street and Numb	er or Rural Route N	umber, City or Towr	, State, Zip Code).
27 is r matic			mphries	19	411. India	n Camp	Koad C	20c. Location -	MD. 21045 City or Town, State
Department of Health ar Important: If item 27 injury or other traums	20a. Method of Dispositi	on	Removal from St	20b. Place	of Disposition (Name tory or other place)				
int: If	4 Donation 5	Other Specify:		Mt. C	armel Cen	netery	1111111	Datting	ore, Manylar
Department Important: injury or of	21. Signature of Funeral				11/1/21	MILLER S	A 1361 1/10	111.6 1 16	//
100	23a. Part I. Enter the dis	sease, or complic	ations that cause	d the death. Do r	not enter the mode of	dying, such as ca	rdiac or respiratory	arrest, shock, or he	art Approximate In Between Onse
sician edical	failure. List only of	ne cause on each	ultiple						Death
miner	Immediate Cause (Fina or condition resulting in		ue to (or as a cons						
	Sequentially list conditi	ons, b	ue to (or as a con	sequence of):					
amine	if any, leading to immed cause. Enter Underlyin (Disease or injury that	ng Cause		_					
	(Disease of Hijdry that	(h) Last D	ue to (or as a con	sequence of):					
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	i	X	23c. If yes, outo	ome of pregnan	2 Fetal death	3 Ectopic	8/22/08 1	23d. Date of Month	
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DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of			iene _{eg. No.} 2008	3 26478	
			Decedent's Name (First, Middle, Last	t)				2. Date of Deatl		3. Time of Death	
	Physici		HARRY COLEMAN	MONTAGU	Æ. Jr.			August	16, 2008	6:40 A. M	
ade	/Medio Examin		4a. Facilify Name (If not institution, give		OL.	4b. City. Town.	or Location of Dea		4c. County of Deal		
	Examin	lei	Gilchrist	,			<i>i</i> son		Baltimor	e	
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birthday	If Under 1 Yea	r If Under 24 Hr	s. 8. Date of Birth	9. Bir	thplace (State or Foreign	
	Director		212-26-8654	M 2□F	79 Yrs.	Months Day	s Hours Min	May 12,	1929 Mar	vland	
			Usual Residence of Decedent		.,			, i.i., i.i.,	1929 1101) Luna	
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Mar a-f st	ţċ	Maryland Balti	nore	Baltin	nore				1 □ Yes 2 □ No	
	r 28	ire	10e. Street and Number			10f. Zip Code	•	11	0g. Citizen of What Co	ountry?	
	3a o	a D	227 Brandon Road	1			21212		U.S.A.		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of	Hispanic Origin?	Specify Yes or No-	14. Race - Ame		
9	or ite		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☐ N	10		ıban, Mexican, Pue	eno nican, etc.)	Black, White		
03	al", c	b	3 ☐ Widowed 4 ☐ Divorced	If Ye s, Give Year or Dates:	1948-54	1 □ Yes 2 🕅 N	o Specify:		Specify: W	nite	
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show 'ited Examinar nust be notified at	Completed by	15. Decedent's Ed (Specify only highest gra		16a. Dece	edent's Usual Occ	upation e during most of w		16b. Kind of Business	/Industry	
7	thin le.	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+) Iife.	DO NOT use retir	red)			_	
7	filed within Hygiene. other than '	ပ္ပြဲ		1 year	Gener	al Wareh	ouse Mana		Printing I	Paper	
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, N	faiden Surname)		
yla	should be filed within and Mental Hygiene. s marked other than umatic event, It e M	၉	Harry Coleman M	ontague,	Sr.		Elizab	eth :	Stockman		
Maryland	and s m		19a. Informant's Name/Relationship (ing Address (Stre			, City or Town, State, .	·	
	1 and 2 Health tem 27 i		Marion H. Montague	e (wif		Brandon	Road Ba	ltimore, 1		21212	
ore	ges 1 It of H If Iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Romaval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other p	lace)	Date 2	20c. Location - City or	Town, State	
Ē	Pages 1 ment of H ant: If Ite ury or ot		4 □ Donation 5 □ Other (Specify		Dulaney Val	ley Memor	ial Grdns.	8-19-08	Timonium,	Maryland	
Baltimore,	permit. Pages 1 ar Department of Hes Important: If Item any Injury or othe once.		21. Signature of Funeral Service Licer	see	2	2. Name and Add	ress of Facility	ld Emeral	Home, Inc	11000	
Ω	88 = 88		Gleon / Fil	un	_	6500 Yo	rk Road	Baltimore	, Maryland	i 21212	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not er	iter the mode of d	ying, such as card	ac or respiratory arre	est,	Approximate Interval Between	
1	Physician		Immediate Cause (Final	one cause on each	march	MIT	CAN	COR	9	Onset and Death	
A	/Medical		disease or condition resulting in death)	a. Due to ras	a consequence of):	10-16	01100	007		1008 401 -0	
7	Examiner			,	, ,						
	-	ē	Sequentially list conditions, if any, leading to limited accuse. Enter Underlying Cause (Disease or injury								
	cuted id ansit	Examin	Cause (Disease or injury that initiated events	C							
o,	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):								
8760,	icate be executed physician and the burial-transit	dical		.d							
		edi									
Вох	death certifi e attending j id for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery	
m.	deatl e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant a		☐ Ectopic pre g na ☐ Other <i>(sp</i> ec <i>ify)</i>			Month	Day Year	
P.0	at the de by the tached	Physician/Me	9 ☐ Unknown	9 🗆 Unknown							
·,	ge d	by P	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	ınderlying cause (given in Part I.	23e. Did tot	pacco use contribute to	o the cause of death?	
Records,	quires in sign	d b						1 □ Ye	s 2 No 3 P	robably 4 🗌 Unknown	
00	w requir s been s should!	Completed						24a, Was a	n 24b. Were a	utopsy findings available	
Re	The law cate has page 2 s	ᇤ						- autops perforn	ned? death?		
Vital	<u>:</u> 8 8	o Be	examiner?	Hospital:	ent 2 🗆 ER/Outpatie	nt 20004 C	thor:	eath (Check only on	ence 6 Other (Spe	Interior	
of	Phys er this eral dir		27. Manner of Death	28a. Date of Inju					ow injury occurred	ecity 0 9 - C	
on	ding P	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, Year) Injury		ork? □Yes 2□No		,,		
Division	Attending r death. ector: After by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be		ury - At home, farm, si	reet, factory, office	9	28f. Location (St	reet and Number or R	lural Route Number.	
5	after Dire	erti	4 Homicide	building, etc	c. (Specify)			City or Town	n, State)	·	
	Hospital or 24 hours afte Funeral Din tely filled in			yslcian: To the best	of my knowledge, dea	th occurred at the	time, date and pla	ce, and due to the c	ause(s) and manner a	as stated.	
1/	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical			f examination and/or i				ate and place, and du		
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certifier	- 1	0	29c. Lice	nse number	2	9d. Date signed (Mon	th, Day, Year)	
	->=o		Al Ann	Trank-	Kuin	0 1	2.120	5 1	trecust.	16 2008	
	, h		30. Name and address of person who	complete cause of d	eath (Item 22n) (Time	Print)	0 -	C , D	109030	16,2008	
	10		30. Name and address of person who	C An	1 P 7	1 No C	leal.	St. Ha	etta. Ma	21500	
	Ste	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							<u> </u>		
	Registr		ALIG 1 8 20		2 15 5	and the second					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ore 9:00 PM AUGUST 2008 14 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat wn, or Location of Death 4b. City Examiner memorias Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day 6. Sex 7. Age (In yrs last birthday) **Funeral** 1□ M 2 F 15-72-Months Days 001 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director Imal 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? ROFT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ADECEO TEMP College (1-4or 5+) Elementary/Secondary (0-12) IA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 16 Pages 1 and 2 should or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sti Balto, md. aaughto 336 2/2/8 Homestead Method of Disposition

Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Pages 1
Department of h
Important: If ite
any Injury or ot 21-08 4 □ Donation 5 □ Other (Specify) Funeral Service Licens 70 Approximate Interval Between Onset and Death 23a. Part 1. Inter use disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocks or neart failure. List only one cause on each line. Immediate cause (Final **Physician** MULTI SYSTEM ORGAN FAILURE week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS SEVERE 2 weeks Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed 1 MONTH PNEUMONIA burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy in the past 12 mort Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by BRONCHITIS 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has prior to codeath? 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: of completely filled in by the f 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated.

To the

Registrar

29b. Signature and title of certifier

SUPNEET

M.D

SALUJA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNION Registrar's agnature

MEMORIAL

29c. License number

AT 2438946

MOSPITAL

29d. Date signed (Month, Day, Year)

August, 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** August ancy, Merritt /Medical 4b. City, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-10-1939 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔯 F 217-34-7279 68 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the live light Exp. nit with the motified at 1 ☐Yes 2 K No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21227 U.S.A. 3014 Georgia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Ernestine Thompson Joseph Martin Gortt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traumonce. Husband Mr. Gordon Merritt, 3014 Georgia Avenue, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State August 19, 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore,_MD 22. Name and Address of Facility Singleton Funeral & Cremation Svs Signature of Funeral Service M00918 1 2nd Avenue S.W. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Obstructive Pulmonary Disease Examiner hronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events couertially list conditi Examine Due to (or as a consequence of) be executed burial-transi resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed Deep vein Thrombosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Anemia this certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 ☑ Natural 2 ☑ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred I or Attending Fafter death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier Ras 000

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DHMH 17 Rev 1/2001

State 31. Registrar

XIAOBING Y 31. Date filed (Month, Day, Year) AUG 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	(Certificate of Death	Reg. N	2008 2	6481
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARUIN		MILES	2. Date of Death Month Di	ay Year 3.7	Time of Death
-	Examin		4a. Facility Name (If not institution, give s HARBOR +	reet and number) 10 SPITAL	4b. City, Town, or Location of Death BALTIMO	RE	c. County of Death	
	Funeral Director		5. Social Security Number 2/7-/8-/39/ Usual Residence of Decement	M 2□ F 7. Age (In yrs, last birth	I Months I Days I Hours I Min	8. Date of Birth (Month, Day, Year	23 Southplace	(Stage or Foreign
	ith the Maryland or 28a-f show or notified at	Director	10a. State 10b. County 10e. Street and Number	10c. City, Town o	10. Zip Code	10g. C		nside City Limits ☑Yes 2☐ No
036	urs after death wi al", or items 23a Expressed to 111	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Ye's or No- D Rican, etc.)	14. Race - American Ini Black, White, etc. Specify.	dian,
id 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Accital Evandrian in unit be notified in once.	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Scolody (0-12)	ation 16a. L completed) (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life BO NOT use retired) 18. Mother's Nam	ing 16b.	Kind of Business/Industry ABDICO on Surname	(tian)
Š	and 2 should be lealth and Mental m 27 is marked on her traumatic ev	To B	Kolu Johnson	Thes/White 2	Mailing Address Treet and Number of Plus 33 March March Livy	e salt	Ma 21	225
Baltimore,	permit, Pages 1 a Department of He Important; If item any Injury or oth		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	(ary	Disposition (Name of crematory of either place) 22. Name and Address of Facility	0/08 /20d.	Location - City or Town, S	State LLX
	Physician /Medical Examiner	ier	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	cations that caused the death. Do not be cause on each line. STAPHYLOCO Due to (or as a consequence of ACUTE Due to (or as a consequence of Due to (or a	ENAL PALWR	BACTE	PFMIA Applinter	proximate erval Between set and Death
68760,8	certificate be executed nding physician and ise as the burial-transit	Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	·):			
B.	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year
rds, P.	requires that the been signed by th hould be detache	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacci	o use contribute to the ca	1/
al Reco	The larate has	Completed	OF Warrant of the day of the			24a. Was an autopsy performed?	death?	etion of cause of
Ζ	Physician: r this certific ral director, I	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 ☐ ER/Out	Othor	tth (Check only one) Iome 5 ☐ Residence	6 Other (Specify)	
Division of Vital Records,	ding h. Afte fune	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury 28b. Ti	me of jury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred and Number or Rural Ro	oute Number,
Ω	Hospital 4 hours Funeral tely filled	Medical Cer			death occurred at the time, date and place d/or investigation, in my opinion, death occu			
	To the within 2 To the complex	Mec	29b. Signature and title of certifier	PHYSICIAN	29c. License number	00 AU	Date signed (Month, Day,	2005
4	1 *		30. Name and address of person who co	3001 COUTH	Type, Print) HANOUER STR	ECT, BAL	TIMORE,	MD 2122
	Sta Regista		31. Date filed (Month, Day, Year) AUG 1 8 2008	32. Registrar's Signature	medi			

DHMH 17 Rev 1/2001

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evanting must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, <

	For State State Registrar	o i wai yianu / D	Certifica				eg. No. 20	08	26482			
an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month August		g ^{Year}	3. Time of Death 10:35 AM			
al er	Paul Edward Nordstrom 4a. Facility Name (If not institution, give street an	d number)	4b. City	, Town, or L	ocation of Death	nugus c	4c. County		10:33 110			
	12821 Three Sisters R			tomac			Montg					
	5. Social Security Number 481-56-8122 6. Sex 1 □ XM 2 □	7. Age (In yrs. last birtl	rs. If Under		Hours Min.	8. Date of Birth (Month, Day June 17	, Year) , 1955	9. Birthp Coun Miss	place (State or Foreign ntry) Souri			
tor	Usual Residence of Decedent 10a. State	10c. City, Town Potomac						1	0d. Inside City Limits 1 ☐ Yes 2 No			
ral Dire	10e. Street and Number 12821 Three Sisters R	oad		ip Code 0854			0	of What Country? I States				
Be Completed by Funeral Director	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. ed Forces? /es 2 ☐ No s, Give or Dates:	13. Was Dece If Yes, sp 1 □ Yes		panic Origin? (Spent), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White, e : Whit				
ompleted	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 5+	eted)	Decedent's Us (Give kind of w life. DO NOT	rork done du use retired)	tion Iring most of worki	ing	16b. Kind of Bu		dustry			
To Be Co	17. Father's Name (First, Middle, Last) Roy Elmer Nordstrom				18. Mother's Name	-		e)				
	19a. Informant's Name/Relationship (Type. Print Kathleen K. Henry/ Wi	State, Zip D 208	854									
	20a. Method of Disposition Maguria 2											
	21. Signature of Funeral Service Licensee	M01346	Rockvi Rockvi	and Address	of Facility Rob Inc. 300 Maryland	vest A. Vesto ^M	Pumphre 2005	y Fui ry Av	neral Home venue			
iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Psuedo Myxoma of Colon Psuedo Myxoma of Colon											
Completed by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		-									
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								ery Day Year			
ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3											
Complet	24a. Was an autopsy performed? 1 □ Yes 2 ♣ No 1 □ Ye											
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou	trationt 2 🗆		26. Place of Deat			(2				
Medical Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. 5 Pending investigation 6 Could not be determined 28e.	red	al Route Number,									
edical (29a. Certifier (Check only one) 1 X Certifying Physician: 2 Medical Examiner: On and	To the best of my knowledge the basis of examination an manner stated.	e, death occurre d/or investigati	ed at the tim on, in my op	ne, date and place, vinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as a	stated. o the cause(s)			
M	29b. Signature and title of certifier Solan Note	Wich m	5	D2842		4	29d. Date signe 8/15/08		Day, Year)			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Galen B. Hallick, M.D. 10215 Fernwood Road, Suite 100, Bethesda, MD 20817											
te ar	31. Date filed (Month, Day, Year) AUG 1 8 2008	32 Registrar's Signature	book	,								

Amend #1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 per MD 8882 8/26/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Venkatasatya 2. Date of Death Krishnarao Peri Month Day **Physician** 16, 2008 6:06 P M Venkatasatya Krishnarad Peri August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Young 10, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ☑ M 2 ☐ F Funeral Year) Months Days Hours Min. 1936 145-02-0340 India Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f sho 1 □Yes 2 NNo Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11409 Tall Forest Circle 20876 India Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Asian Indian δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government of India College (1-4or 5+) 27 is marked other than 'traumatic event, I've Me Elementary/Secondary (0-12) Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be l and 2 should be fi Health and Mental I Sundararamayya Peri Subhadramma Ganti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any injury or other trau Vijaya Gowri Peri/Wife 11409 Tall Forest Circle, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 18, August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, MD Pumphrey Funeral Home/ 755 Wisconsin Ave. 2008 M01346 Rethereda, MD 20814 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE ACUTE **Physician** /Medical Due to (or as a consequence of): Examiner MALIGNANT HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): nei certificate be executed burial-transit Exami aftending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Machain D0062562 HUGG AUGUST 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE MAKYLANT MD MADHAVI HUBBLY AUG 18 32 Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Yea **Physician** _A M 8 2008 6:15 August Sundergill Powe 11 Irva /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Lutheran Health Care Ctr. Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 15, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 212-05-5045 94 1914 Maryland Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 ☐ No Director Maryland Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 230 St. Mark Way 21158 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) billing clerk gas & electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nena Sundergill မ Joseph Gilbert Ensor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 191, 303 S. Main St. Woodsboro, MD21798 Margaret P. Trimmer/niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Hope Cemetery 8/18/2008 Woodsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sign to e of uneral Service Lie att Jarine New Windsor, MD 21776 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BENWATERIN disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Physician: The law requires that the death certificate be executed Due to (or a) consequence of): sician and burial-tran physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, á 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 ☐Yes 2 ☐ No 2 No 1 □Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After t 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending investigation after death.

I Director: Af in by the fu 1 ☐ Yes 2 ☐ No within 24 hours after dec To the Funeral Directo completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examiner wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

For and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's S

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1420 John A. Reger 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 XM 2 ☐ F 87 Baltimore, MD Director 217-18-2953 11/03/1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f sh notified MD 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 3724 Clarenell Road 21229 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 Widowed 4 Divorced er than "natur, Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Department Manager Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Frank A. Reger Isabelle (Unknown) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Virginia Schoeffner (Daughter) 3933 Plantation Drive, Marietta, Georgia 30062 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 08/20/2008 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Made 1: 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the "sea" complications that caused the shock, or heart failure. List only one cause on each line. Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final **Physician** schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Derte if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed per physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 ☐ Yes 2 No Vital 1∐ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 44 hours after death. Division 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 N Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of ermier 29c. License number 29d. Date signed (Month. Dav. Year)

10x,

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAO

32 Registrar's Signature

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31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:44P M August 12, 2008 ROSALIE ELAINE ALCARESE RALLO 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County GILCHRIST CENTER Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days Months Hours 1 □ M 2 🗓 F Feb 20, 1927 Maryland 217-22-3814 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Maryland Baltimore County Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 Malibu Court 21204 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rectory Staff Member Christian Ministry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luigi Alcarese Cefalu Antonia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Toni R. Guckert (Daughter) 5 Malibu Court, Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mausoleum 8/15/08 Timonium, Maryland 21. Signatur, of Function Service Charles

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAUS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed KIONEN DISEASE HRDNIC 1 □Yes 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\text{Other} \text{ (Specify)} \) \(\text{HOSPICE} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** /Medical Examine death certificate be executed

Important: if Item 2 any injury or other once.

Baltimore,

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To the Hospital of within 24 hours af To the Funeral Di completely filled in

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3 ☐ Suicide 4 🗍 Homicide

29a. Certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and titl

D64395

29d. Date signed (Month, Day, Year) AUGUST 13, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NCHARLES STI SUITE 209 CANTIMORE, MO 21208 DANIEUE OBBERMAN, MS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#28c perPHYS, G882,8/18/08,WS State of Maryland Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** Earl Ramp August 8, 2008 7:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 406 Shady Nook Avenue Catonsville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** Vear Months Days Hours 1 ☑ M 2 □ F May 28, Director 1936 Pennsylvania 203-28-7084 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f showerent, the Medical Examination must be notified at 1 TYes 21€ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 406 Shady Nook Avenue 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 No 2 No 1f Yes, Give Year or Dates: 1955–57 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Terminal Operator 12 01117. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fill f Health and Mental H tem 27 is marked ott Earl Ramp 2 Cora Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27.
any injury or other tra Michael Ramp 406 Shady Nook Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cemetery | 8/15/08 4 ☐ Donation 5 ☐ Other (Specify) Coal Township, PA 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARKAIO SCIEROTE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy for L in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy performed? 1 Yes 2 ANo Deflerbert

25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 2 ☐ Accident death. 1 □ Yes -2 1 1 1 after death 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: completely filled in by the To the Hospital within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oger

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

TOWSON, MARYAND

29d. Date sigged (Month, Day, Year)

2008

14		For State Registrar 1. Decedent's Name (First, Middle, La	Type or Print 1 items 25. AMEND ITE		Departme c per FH <i>Certifica</i>	nt of the G882 ite of	lealth and Death	Mental Hy		2008	3. Time of Dealer	
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7 is m traum		19a. Informant's Name/Relationship (Anthony Barnes								ty or Town, State, Zip Code) OWN, PA 17313		
If item 27 or other tr		20a. Method of Disposition	5011		of Disposition (A tery, crematory of lemorial		-	Date	20c. Lo	ocation - City or	Town, State	
Important: If any Injury or once.		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	fy)	Ling N	a klag	e ce	metery ess of Facility	8/11/0	8 P	ndallst ikesvi	lle, Md	
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ne attending physician ed for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 26□No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown						23d. Date of de Month	elivery Day Year		
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Director: Aft	ertil									Hury	Maryland manner as stated.	
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To the Funeral Director: After Completely filled in by the fun		29b. Signature and title of certifier 30. Native and address of person who	miner: On the basis of and manner sta	examination	a) (Type, Print)	on, in my o	se number	urred at the time	29d. Da	d place, and dute signed (Mon	th, Day, Year)	

08-05630 James Ross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 26489 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 19, 2008 1300 hrs Medical Examiner JAMES ROSS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Laurel Regional Hospital Laurel 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Davs Hours Director 7-1-1962 Country) MARY LAND 46 215-76-0037 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No , or items 23a or 28a-f show r must be notified at once. MD. N/A BALTIMORE Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 4237 PASCAL AVE. 21226 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. marked other than "natural", or items c event, the Medical Examiner must be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes BLACK Yes 2 X No specify: Specify: If Yes. Give Year Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 in nent of Health and Mental Hygiene. MD 21215-0036 -12--2-WRITER MUSIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES ELLIOTT AGNES ROSS Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print AGNES PLAYER (MOTHER) 4237 PASCAL AVE. BALTIMORE, MARYLAND 21226 item 27 is 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date timore, crematory or other place) X Burial mation 3 Removal from State tment Other Specify ZION CEMETERY 7-29-2008 BALTIMORE. Donat D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licer MAHTANOS 1721-27 N. MONROE ST. BALTIMORE. MARYLAND 2121 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and ure. List only one cause on each line /Medical Death Perforated duodenal ulcer with complications Immediate Cause (Final disease or indition resulting in death) xamine Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, perME, g882 8/20/08 TT X UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy death? performed? Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: 1 ✓ Inpatient 2 Other: DOA Nursing Home 5 Residence 6 Other ER/Outpatient 3 this 1 V Yes မှ No n 24 hours after death.

e Funeral Director: After thi
detely filled in by the funeral d 28a. Date of injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal within 24 To the F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title certifi O.C.M.E. July 24, 2008 person who completed cause of death (Item 23a) 30. Name and address Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Riperie MD. OCME 31. Date filed (Month, Day, Year, 32. 'Registrar's Signature State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 26490 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** 255 AM Shaw 15 2008 Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITA Maryland N/ABaltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 90 Months Days Hours Min. Country) Louisiana 1 □ M 2 F November 18,1913 Director 053-38-4555 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland popertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TylYes 2 □ No Director Maryland N/ABaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 830 West 40th. Street 21211 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Sharman Martha Dyer ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 19a. Informant's Name/Relationship (Type. Print) Helen S. Davis (daughter) 111 Hamlet Hill Road #1414 Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 8-18-08 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOGENIC SHOCK **Physician** 30 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Infarction + hours Examiner INTERIOR MA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial P.O. Box 68760, physician Physician/Medical the ndina as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown atte for t 3 Ectopic pregnancy 5 Other (specify) ed by the detached 1 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation hours after death.
uneral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Settifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year) 2008

BENJAMIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32: Registrar's Signature



129391

Greene tree Road

Registrar

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8, perfil, 6882, 8726 / 08, WS
State of Maryland / Department of Health and Mental Hygiene 2008 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A UGUS V Year 6:20 PM **Physician** 4c. County of Death Emma Virginia Thalberg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel 1108 Marley Creek Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Augnth, Pay Yeal 919 **Funeral** Months Days 1 □ M 2/X F Hours Min. Director MD 89 218-07-9587 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Worldal Evanings must be notified at 1 ☐ Yes 2 ☐ No Director <u> Anne Arundel</u> Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21060 1108 Marley Creek Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 XXO
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√XNo Specify. Specify: Completed by 3 Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelmina Smith Charles E. Ittner P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 1630 Witt Drive, Glen Burnie, MD 21060 Rhonda Witt Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once, 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Aug 19, 2008 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature to File and State of U. 22. Name and Address of Facility P.A. 426 Crain Hwy S., Glen Burnie, MD Gregory Fink M01148 23a. Part 1 Enter the disease, or omblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or a a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached f 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 Wo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No hours after death. investigation Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

10

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause/of death (Item 23a) (Type, Print)

32. Registrar's Signature

RUBEN

31. Date filed (Month, Day, Year)

22609

FURNACE BRANCH Rd GLEN BURNIE HD 21060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death Month **Physician** 2008 /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and nu Examiner VAMEdiCAL BALTIMORE timuRe Center If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑** M 2□ F Yrs Director 216-34-7544 70 02 05 38 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b, County "natural", or items 23a or 28a-f show edical Examiner must be notified at Y∏Yes 2 No Directo Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. Drive 6190 Northwood by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 TYes 2 No f Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Murry Steak House General Manager 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Agnes Smith George Terry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6190 Northwood Drive, Baltimore, md 21212 Renee Terry-Wife Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Metro Crematory Inc 8/19/08 Baltimore, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cuncel /Medical Due to (or as a con. a uence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital c within 24 hours af To the Funeral D completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State

29b. Signature and title of certifier

31. Date filed

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Registrar

10 NOR

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** August 13, 11:57 PM Shirley Anna Louise Tregoning 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shepherds Glen Union Bridge Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 27,1933 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ XF 74 Mary land 475-60-6909 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be rectified at 1 □Yes 2 TXNo Director MD Carroll Westminster with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1392 Alison Court 21158 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examina 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 White 1 □Yes 2 X No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Edward Stambaugh Ethel Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maurice T. Tregoning, Sr/husband 1392 Alison Court, Westminster, MD 21158 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Lutheran 8/17/2008 Uniontown, MD 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hyears **Physician** Zheimer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter trinderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

32. gistrar's Signature

d cause of death (Item 23a) (Type, Print)

AUG 1 8 2008



WD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneo

	Physicia	an	For Amend Items 23a, 25, 27, 28a-f Departing the Registrar 1. Decedent's Name (First, Middle, Last)	me 1885 08/ 65/0	2. Date of De Month	ath Day Year	3. Time of Death		
1	/Medic	al	LENA S. THOMAS 4a. Facility Name (If not institution, give street and number) 4	lb. City, Town, or Location of Deat	JULY	19 200 4c. County of Dea	1.20		
a grape	Funeral Director	e.	JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	HTTTMORE If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birt	y, Year) C	thplace (State or Foreign ountry)		
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State	tion			10d. Inside City Limits 1 □ Yes 2 □ No		
	th with the 23a or 28a	al Director	10e. Street and Number 6225- A Elrino Street	10f. Zip Code 21224		10g. Citizen of What C			
980	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ont, the Medical Evantiner must be prefilled at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 21X No _	s Decedent of Hispanic Origin? (\$ es, specify Cuban, Mexican, Puer ∃Yes 2 ☐ X No Specify:	Specify Yes or No to Rican, etc.)	- 14. Race - Am Black, Whi Specify: Whi	te, etc.		
21215-0036	within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade completed) (Give kin life. DO	nt's Usual Occupation and of work done during most of wo NOT use retired) HOmemaker	rking	16b. Kind of Business Own Hom			
	be filed ntal Hygi ed other event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na		st, Middle, Maiden Surname)			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "factal Examiner must be notified at once.	70		Marie Address (Street and Number or R			Zip Code)		
Baltimore, M			Mrs. Lisa Plummer/ Niece 6614 I 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 ➡ Donation 5 □ Other (Specify) St. Stanis	Date	re, Marylan 20c. Location - City of Baltimore,	Town, State			
Baltii	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee 22. N	Name and Address of Facility Du 22 Wise Avenue I	ida-Ruck	F.H. of Du	ndalk, Inc.		
68760,	Physician patentilicate pe executed attending physician and physician are as the purial-fransit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	the mode of dying, such as cardia	1/4		Approximate Interval Between Onset and Death		
O. Box	the death certific y the attending p ched for use as I	Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of do Month	elivery Day Year		
rds, P.	quires that the de en signed by the a uld be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4			
Division of Vital Records,	I or Attending Physician: The law requires that the death cer after death. Director: After this certificate has been signed by the attendir in by the funeral director, page 2 should be detached for use	e Completed	25. Was case referred to medical	26. Place of De	24a. Was auto perfo 1 □ Yes ath (Check only o	psy prior to ormed? death? 2 ☑No 1 ☐ Ye	autopsy findings available completion of cause of		
of Vi	Physici this cer al direc	To Be	examiner? 1 N Yes 2 FR/Outpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing	Home 5 ☐ Resi	dence 6 ☐ Other (Sp	ecify)		
ion	ath. r: After ne funer	ation	27. Manner of Death 1	28c. Injury at Work? M 1 □ Yes 2 X No		ole fall.			
Divis	oital or Atteurs after de ral Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Home 28e. Place of Injury - At home, farm, street building, etc. (Specify) Home	t, factory, office	Apt. A,	Baltimore,			
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the best of my knowledge, death of the best of examination and/or investigated. 29b. Signature and title of certifier	occurred at the time, date and place stigation, in my opinion, death occurred.	ce, and due to the urred at the time,	cause(s) and manner date and place, and du 29d. Date signed (Mor	re to the cause(s)		
	5. ₹ 5 8		B M.D.						
	(V)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri				V		
l	Sta Registr		RYAN LT M.D. 4940 EASTERN AVENUE 31. Date filed (Month, Day, Year) AUG I 5 2008 32. Rigistrar's Signature AUG I 5 2008	BALTIMORE, A	nd 2 12	24			

			1 - For Amend #26, pe	State of MerMD, G882	arylan 8/18,	d / Depa /08 ਟੂਟ੍ਰ,	irtment of I	Health a	and M	lental Hy	giene	2008	2649	5
		ž	Negistrar Necedent's Name (First, Middle, L.)				imouto or			2. Date of De				Ų
	Physici /Medic		Bernard F. Uhd	en						August	E 12	2, 2008	10:05A M	t
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or Location of Death				4c. County of Death			
7			1235 Haverhill	Road			Balti				n/a			
	Funeral Director		217-34-4061	Sex 7. Ag	ge (In yrs. I 70	ast birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da 3 / 6 / 1	h y, Year) 938	9. Birth Coul Mary	olace (State or Foreign ontry) /land	n
	and w		Usual Residence of Decedent 10a. State 10b. County	•	10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Aaryk f sho ed at	ō	MD Wicom	i ao	,		onsberg						1 □ Yes 2 No	
	the 128a-	Director	10e. Street and Number	.100		rais	10f. Zip Code				10g. Citi	izen of What Cou	ntry?	_
	3a or		7104 Walston S	witch Ro	ad		218	49		ĺ	τ	JSA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Decedent of I f Yes, specify Cub	Hispanic Or	igin? (Spe	ecity Yes or No	.	14. Race - Americ		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ▼ Married 3 ☐ Widowed 4 ☐ Divorced				Yes 2X No			nicari, etc.)		Black, White, Specify: V	vhite	
2	72 ho natur lical	Completed	15. Decedent's l (Specify only highest g	Education (rade completed)		16a. Deced	lent's Usual Occu	pation	st of worki	ina	16b. Ki	ind of Business/In	dustry	
7	ithin ne.	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done OO NOT use retire	•		,,g				
7	lygier		12	0		Mach	ine Ope	T		/F' 14: 1-	*****	Baking		
and	be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last William Uhden,	*						e (First, Middle, Cine Ca		,		
ž	d Mer narke	2	19a. Informant's Name/Relationship			10h Mailin	a Address (Ctros					or Town, State, Zij	- 0-4-)	_
S	d 2 sl th an th an traur		Joseph C. Uhden				Haverhi.						o Code)	
	Heal Heal tem 2		20a. Method of Disposition		20b. P	1	sition (Name of natory or other pla			Date		ocation - City or To	own, State	_
Ö	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic e once.		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				natory or other pla Mem。Pk。		3/15/	2008	Syke	esville,	MD	
altimore,	nit. F artme ortan Injur		21. Algnatur of Funeral Service Lic		Las		. Name and Addr					ral Home		
ñ	any any		Subant	i Imile	~	4	07 Wilke	ens Av				e, MD 21:	•	
-			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death					-		,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	, meta	98.1	tic	lung	cano	Ngo				Onset and Death Month	
1	/Medical		resulting in death)	Due to (or as			J	Cont					i fricitivi	_
8	Examiner		Sequentially list conditions,	b. ———										
7	D #	iner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury											
/	ecute and -trans	Examiner	that initiated events resulting in death) Last	uence of):	of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	a E		Due to (or as	a consequ	derice ory.								
387	icate phys s the	dical		▲ d										
×	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of deliv	erv	
Box	death atter	ciar	in the past 12 months?	1□Live birth 4□Pregnant a			lEctopic pregnand Other <i>(specify)</i> _	СУ			1	Month	Day Year	
Ö.	t the cay the achec	hysi	9 Unknown	9□Unknown										
ď.	ires that the de signed by the a l be detached f		Part II. Other significant conditions	contributing to death t	out not resu	ulting in the ur	nderlying cause gi	ven in Part I	l.	23e. Did t	obacco u	use contribute to t	he cause of death?	
Records,	w require been sig should b	ed t								¹X(Yes 2	□ No 3□ Pro	bably 4 □Unknowr	1
000	law re as be	Completed by								24a. Was		24b. Were auto	opsy findings available	9
m —		ĕ							_	perfo	rmed? 2 X No	death?	2 ⊠No	
Vita	Attending Physician: The law ir death. ector: After this certificate has tby the funeral director, page 2 s	Be	25. Was case referred to medical examiner?					26. Place	e of Death	(Check only o			Residence	_
7	≥ .º 0	ု	1 Yes 2 No			ER/Outpatien	COLIDON		ursing Ho			6 XOther (Speci	fy)	
Ē	Ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury a <i>y Year)</i>	28b. Time of Injury	Wo			28d. Describe I	now injur	ry occurred		
S	ttend leath. ttor: /	cati	2 Accident investigati 3 Suicide 6 Could not	he	ium. At ho			Yes 2		201 1	24 4			
Division or	or A after of Direction by	Certification:	4 ☐ Homicide determine	d building, e	tc. (Specif)	/)	eet, factory, office		1	City or Tou		nd Number or Rur e)	ai Houte Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying I	Physician: To the best	of my kno	wledge, death	occurred at the t	time, date a	nd place	and due to the	cause(s)) and manner as	stated.	_
	e Ho	Medical		aminer: On the basis of and manner st	of examina	tion and/or in	vestigation, in my	opinion, de	ath occurr	red at the time,	date and	d place, and due	to the cause(s)	
	Within To th	Me	29b. Signature and title of certifier	1			29c. Licen	se number			29d. Da	te signed (Month,	Day, Year)	
			1 Kasalyn	/ july	roman		D	602	03		Augi	ust 13	2008	
			30. Name and address of person wh	o completed cause of	death (Item	23a) (Type,	Print)						21231	_
_	9		Rosalyn Juergens, w	5 1650 or	leans	Street	Johns	Hopkil	ns c	RBI-G	93 1	Baltimore	2008 21231 Mary land	l
	Sta		31. Date filed (Month, Day, Year)	2008 32 Regist	rar's Signa	ture A	aste!							
	Registi	ar	AUG 18	"OOO THE	KI A	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / De State of Maryland / De Registrar	partment of Health and IV ertificate of Death	лептаг пу	Reg. No.	108	26497
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Harry Stanley Welsh		2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic			4b. City, Town, or Location of Death	Augus		2∞8 ty of Death	4:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	Baltimore		46. Coun	ity of Death	
~	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo		8. Date of Bir (Month, Da	th av Year)	9. Birthp	lace (State or Foreign
	Director		214-34-0378 1 TX 2 F 72 Yrs	Working Days Flours Will.	Sept 2	1935		MD
	and Jw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	_	-	10	0d. Inside City Limits
	Mary I-f sh	ţo	MD Carroll Sykesvi	11e				1 □Yes 2 □XNo
	or 282	Sire.	10e. Street and Number	10f. Zip Code		10g. Citizen o	f What Coun	try?
	ath wi	Funeral Director	2832 Lake View Avenue	21784		USA		- 1-1
_	items	un.	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	D- 14. H	ace - Americ lack, White, e	
030	urs af	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2 📉 No Specify:		Spec	eify: wh	nite
12-0036	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Frontine must be notified in	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	ing	16b. Kind of	Business/Inc	lustry
7	within ene. than '	dmo	Flomontany/Secondany (0.12) College (1.4or 5±)	e. DO NOT use retired) creational therapis		State	of Mar	yland
V	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam				
land	2 should be and Mental is marked o aumatic eve	10 B	John Henry Welsh Sr.	Mary Ed	lna Picl	kett		
Mary	#7 # P	8		ailing Address <i>(Street and Number or Rui</i> 8 Oak Road, Haletho			ın, State, Zip	Code)
more,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.			sposition (Name of rematory or other place) 1 and Cemetery 8-20	Date 0-08	20c. Location Sykesv	-	
Dairimo	permit. Departm Importar any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of FacilitHais P.O. Box 195 Sykes				hapel
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	-				Approximate Interval Between
-	Physician	7	Immediate Cause (Final					Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a confequence of):					, ,
		ē	Sequentially list conditions, if any, leading to immediate Due to or as a consequence of):	aus injury			-	> 3 days
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence of): Myocrdial Due to (or as a consequence of):	in Farct				> 4 dys
Ď,	tificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):					,
2/PC	cate b	edical	d	<u>, , , , , , , , , , , , , , , , , , , </u>			-	
			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. [Date of delive	erv
.C. BOX	requires that the death cer een signed by the attendir nould be detached for use	Physician/N	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
ī,	s that gned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did	tobacco use co	ontribute to th	ne cause of death?
ecords	equire en siç ould b	ted k			1 🗆	Yes 2 □ No	3 ☐ Prob	pably 4 Unknown
Hecc	To the Hospital or Attending Physician: The law requires that the de within Lat hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed			24a. Was auto perf 1 □ Yes	psy ormed?	b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
V Ital	cian: ertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Dea	th (Check only	one)		
0	Physi rthis c	<u>۵</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim			how injury occ		y)
0	Attending ir death. ector: After by the funer	rtion	1 ☐ Matural 5 ☐ Pending (Month, Day, Year) Injui 2 ☐ Accident investigation		Edd. Bebonibe	now injury coo	unou	
IVISION	or Atter ifter dea Director in by the	Certification: To	3 ☐ Sulicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location City or To	(Street and Nui wп, State)	mber or Rura	al Route Number,
_	spital lours a neral C		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	, and due to the	e cause(s) and	manner as s	stated.
	he Ho in 24 t he Ful pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/cone) and manner stated.	r investigation, in my opinion, death occu	rred at the time	, date and plac	e, and due to	the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier Alcheich MD	29c. License number		29d. Date sig		
	. h			AT 243891			116	- 2008
	12		30. Name and address of person who completed cause of death (Item 23a) (Tyle Elie Alcheith MD Union	Memorial Ho	spital	1	NI	
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1. 10.				
	Registr	ar	MIC 1 8 2008 Steeren St. 19	pare				

			1 - For State Registrar	State of Ma	ırylan			nt of H te of L				jiene _{leg. No.} 2 (800	26498
Н	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month AUGUST	th	Ž [©] 008	3. Time of Death
1. 100	/Medic Examin	al	SIMON 4a. Facility Name (If not institution, giv	e street and number)		WEI	NSTO 4b. Cit	, Town, or	Location (of Death	AUGUS		2008	1:10A M
~	LAdiiiii	er	LEVINDALE HEBREW	,			BALT	IMORE					N/A	
Н	Funeral Director		5. Social Security Number 6. S 218-10-7820	ex 7.Age XXM2□F	(In yrs. 1	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. (8. Date of Birth (Month, Day 05/19/			ace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	y, Town or Lo	cation						10	Od. Inside City Limits
	Maryl.	tor	MD N/	A		LTIMOR								1 X Yes 2 □ No
	or 28k	Director	10e. Street and Number	. <u></u>			10f. Z	ip Code			1	0g. Citizen o	of What Count	try?
	sath w	Funeral	6203 WALLIS AVE	NUE 12. Was Decedent E	iver in 111	6 42.1	Nos Dos	adont of Ui	2121		ifu Vo a ar Na	14 5	USA Race - America	on Indian
036	should be filed within 72 hours after death with the Maryland rind Mental Hygiene. In the Hygiene in marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinational Leading at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N N If Yes, Give Year or Dates:				ecify Cuba	n, Mexicar		cify Yes or No- ican, etc.)		llack, White, e	
5-0	72 ho "natur	eted	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Dece	kind of w	ork done d	uring mos	t of working	7	16b, Kind of	Business/Ind	ustry
21215-0036	d within giene. er than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`life. I	DO NOT	use retired, GGER)			SEVE	N MILE	MARKET
Maryland	should be filed nd Mental Hygi marked other imatic event, I	To Be (17. Father's Name (First, Middle, Last) ISAAC		WE	INSTOC	K			er's Name (PPORAI	(First, Middle, i	Maiden Surn	_{ame)} UNKI	NOWN
Mary	Train train	_	19a. Informant's Name/Relationship (Type. Print) FRIEND		19b. Mailin	g Addres				Route Number	-	vn, State, Zip 21215	Code)
_	1 an Heal em 2 em 2 ther		20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	ame of	1	Da Da			n - City or To	wn, State
Ê	0 0 		1 Å Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			emetery, cren HAARE I				08/15	/2008	BALTI	MORE, N	4D
Battimore,	permit. Pag Department Important: I any injury o		21. Signatura of Funeral Service Lice	Sugu	/						LEVIÑS OAD - I			INC. MD 21208
۰ _. F	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	o ications no caused one caus of each line	the death e. ENA	Do not ent	er the mo	ode of dying	g, such as	cardiac or	respiratory arr	est,	173.4	Approximate Interval Between Onset and Death
•	/Medical Examiner		resulting in death)	Due to (or as a										weeks
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	executed n and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequ	ience of).								
	icate be executed physician and s the burial-transit	dical		d										
	To the hospital of Attending Physician: The law requires that the death certific within 24 bours after death. To the Furbural Director: After this certificate has been signed by the attending ploompletely filled in by the funeral director, page 2 should be detached for use as to ompletely filled in by the funeral director, page 2.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregna 2 🔲 Fetal] Ectopic	pregnancy					Date of delive	,
5	the degraph of the arrangement o	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of d		Other (IVIONIN	Day Year
as, r	signed I	Ď	Part II. Other significant conditions of			ilting in the ur	nderlying	cause give	n in Part I.					e cause of death?
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	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on			
SION OF	g Phy ter this neral d	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injur (Month, Day	у	28b. Time of		28c. Injury	at		e 5 ☐ Reside			<u>') </u>
	tendin leath. tor: Af the fur	catio	1 🕅 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			Injury	М		r ′es 2 🔲 I					
2	tal or Al	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry - At ho . <i>(Specif</i> y	me, farm, stre	eet, facto	ry, office		28	3f. Location (Si City or Town	treet and Nu n, State)	mber or Rural	Route Number,
	e nospr 24 hour e Funer letely fill	Medical		ysician: To the best on niner: On the basis of and manner stat	examinat									
	Nithin To the comp	Me	29b. Signature and title of certifier				29	c. License				9d. Date sig	ned (Month, £	Day, Year)
			May	- m				()	303	77		Auj	ust 15	,08
-	3		30. Name and address of per on the RUB FACT M. COUPE	completed cause of de	eath (Item	23a) (Type, I	Print) K 1+	Elalt	75	AVE	. 134	CT. M	D 21	215
Ī	Stat Registra	te	31. Date filed (Month, Day, Year)	32 Registra			19.5							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **AUGUST** 4:30A WILKOWSKY 14 2008 KAREN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PIKESVILLE BALTIMORE 205 OLD CROSSING DRIVE Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Hours Months Davs WASHINGTON, DC 02/09/1964 070-42-3134 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b County 1 Tyes 2 No BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 205 OLD CROSSING DRIVE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 N Married 1 ☐ Yes 2 X No Specify WHITE If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY LEGAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARION PETER H₀CH ROTHSCHILD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 OLD CROSSING DRIVE, PIKESVILLE, MD LEON WILKOWSKY / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/15/2008 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mary 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic breast cancer 3 yeurs disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modieri Evantmer must be netitied at once.

3altimore, Maryland 21215-0036

Examiner Physician/Medical ≥

burial-trans and physician a the burial attending pt I for use as t icate has been si Completed certificate Be After this Certification: To funeral To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After the filled in by

	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
ı	IE EEMALE:	

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 No

•	d
	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

2 No

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an
autopsy performed?
1 □Yes 2 No

3 Probably 4 Unknown

26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Day

Į	25.	Was case		to	medic
i		examiner	?		
i		1□Yes	2 🕅 No		

27. Manner of Death 1 Natural 2 Accident 3 Suicide

5 ☐ Pending investigation 6 Could not be determined

Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number 045432

29d. Date signed (Month, Day, Year) August 14, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a (CVOSSVOORS Drive #400 CWIUS MIlls, MD21117 amara S. Schel, MD 31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

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Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 **Physician** AŬĜUST 2008 11:27A M NIEVE WASSERMAN LINDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE REISTERSTOWN 304 WEMBLEY ROAD 8. Date of Birth (Month, Day, Year) 02/20/1947 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MARYLAND 1 □ M 2 X F Months Days Hours Min 213-52-8694 61 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanines must be notified at Director MD BALTIMORE REISTERSTOWN 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than ".... any injury or other traumatic." USA 304 WEMBLEY ROAD 21136 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARTIST ÄRT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRIED MARY RUTHERFORD ပ MELVIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL WASSERMAN / HUSBAND 304 WEMBLEY ROAD, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HAR ceretary elements (Name of HAR ceretary elements)
ISRAEL 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/15/2008 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy certificate ha performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation I hours after death. uneral Director: Af ely filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) An 24 hour. The Funeral Dir. determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 2411 WEST BELVEDERE AVENUE, #509, BALTIMORE, MD 21215 JONATHAN DUBIN, MD 31. Date filed (Morith, Day, Year) 32. Registrar's Signature State

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Registrar

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